S. Hrg. 98-332 Pt. 1

# ADMINISTRATION'S FISCAL YEAR 1984 BUDGET PROPOSALS—II

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# HEARINGS

BEFORE THE

## COMMITTEE ON FINANCE
## UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

FIRST SESSION

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JUNE 15, 16, 22, 23, 28, AND 29, 1983

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PART 1 OF 4

(JUNE 15 AND 16 SPENDING REDUCTIONS)

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# ADMINISTRATION'S FISCAL YEAR 1984 BUDGET PROPOSALS—II

WEDNESDAY, JUNE 15, 1983

U.S. SENATE,
COMMITTEE ON FINANCE,
*Washington, D.C.*

The committee met, pursuant to notice, at 10:02 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Robert J. Dole (chairman) presiding.

Present: Senators Dole, Danforth, Chafee, Wallop, Long, Bradley, and Pryor.

[The press release announcing the hearing, Senator Dole's opening statement follows:]

[Press Release No. 83-144]

## FINANCE COMMITTEE ANNOUNCES HEARINGS ON FISCAL YEAR 1984 BUDGET PROPOSALS

Senator Robert J. Dole (R., Kans.), Chairman of the Senate Committee on Finance, today announced hearings for June 15, 16, 22, 23, 28, and 29, 1983, on budget proposals for programs within the jurisdiction of the committee.

"The Williamsburg Summit Conference produced a clear message that Congress must act to reduce the projected Federal budget deficits to avoid jeopardizing the global economic recovery." Senator Dole stated, "In my view, the only 1984 budget blueprint that is likely to result in actual reduction of the deficit will be one that places the primary emphasis on spending reductions rather than on tax increases."

"Any new revenue—if needed—should come from tax reform not tax increases. The hearings I am announcing today should assist the Finance Committee in preparing to implement any balanced and responsible budget compromise that may emerge," Senator Dole concluded.

The hearings will begin on each day noted at 10:00 a.m. in Room SD-215 of the Dirksen Senate Office Building.

The following is a schedule of hearings:

### SPENDING REDUCTION HEARINGS

On June 15th and 16th, the committee will hold hearings on the Administration's spending reduction proposals within the jurisdiction of the Finance Committee. These include the medicare, medicaid, supplemental security income (SSI), Aid to Families with Dependent Children (AFDC), Child Support Enforcement (CSE), and the Child Welfare, Adoption Assistance, and Foster Care programs.

### TAX HEARINGS

*Fringe benefits*

On June 22nd the committee will hold a hearing on the Administration's proposal to cap the amount of employer-provided medical care that may be excluded from an employee's income. At that time, the committee will also review the public policy and tax compliance implications of the present law tax treatment of other statutory and nonstatutory fringe benefits and the effect of the moratorium on fringe benefit regulations which is scheduled to expire on December 31, 1983.

*Tax compliance*

The hearing on June 23rd will be devoted to possible measures to reduce the $100 billion annual tax compliance gap. The committee will explore the effectiveness of withholding and additional reporting requirements, as well as increased penalties and interest, in encouraging tax compliance. The committee will also be interested in possible changes in the substantive tax laws which may increase compliance. In addition, the committee will address the role of tax professionals, as well as taxpayers, in increased tax compliance efforts.

*Tax expenditures*

The hearings on June 28th and 29th will review the list of Federal tax expenditures. In announcing the hearings, Senator Dole noted, "While there may be a consensus that certain tax expenditures are justified such as the home mortgage deduction, for example, we have an obligation to review special tax breaks enjoyed by certain individuals or businesses to decide whether they are still functioning as intended and whether a particular incentive is justified in today's economy or could be more carefully designed to accomplish the desired public policy goal more efficiently."

## OPENING STATEMENT OF SENATOR DOLE

This morning we begin a series of hearings on spending proposals for programs within the jurisdiction of the Finance Committee. Although the budget process is incomplete, this committee is moving to complete its hearings so we might be prepared for legislative action.

Today and tomorrow we will hear testimony from the Administration and the public on the Administration's spending reduction proposals for medicare, medicaid, maternal and child health, and the income security and social services programs under the Social Security Act, such as AFDC, SSI, and child support. While reductions in entitlement spending will be difficult, the Finance Committee must be ready to do its share to bring down the deficit.

Indeed, the record will show that the committee has exceeded its spending reduction targets the last two years: in 1981, three-year outlay reductions of $26.7 billion was achieved; and $17.5 billion was cut last year in TEFRA. Already this year, the social security solvency amendments have achieved outlay savings of $3.0 billion for fiscal year 1984. Yet with deficits projected at $200 billion for the next several years, there is need for restraint in all programs.

### HEALTH PROGRAMS

For medicare, budget deficits are not the only problem. The medicare trust fund is, as you all know, rapidly approaching a period of time in which it will no longer have sufficient funds to finance health care expenditures for the elderly. Under current assumptions the program will reach this point in 1987 or 1988 unless something is done to moderate its growth.

No single change is likely to be enough to solve the financing problem. However, some limited additional reductions in the rate of growth are critical at this time. The Administration's proposals for medicare are intended to curb the growth in Federal health care expenditures by encouraging providers to dispense services in a cost efficient manner and discouraging beneficiaries from overutilization of services. For medicaid the proposals are intended to stimulate cost conscious behavior, maintain incentives to moderate program growth, and improve program operations efficiency.

### INCOME SECURITY AND SOCIAL SERVICES

This committee has a record of careful, compassionate study of spending reforms in the income security and social services programs. For the past two years, we have evaluated measures proposed by the Administration with the overriding goal of preserving the basic safety net of income security programs while reducing or eliminating unintended and unwarranted benefits. Our guiding principle has been the belief that income security programs should target scarce resources to those most in need and those who cannot provide for themselves and their families. I am convinced that the reforms voted by this committee, many now in the law, have met that requirement.

The changes proposed by the Administration this year are intended to assure that limited Federal and State resources are spent as effectively as possible. The Administration believes that these reforms will complement those made in the Omnibus

Budget Reconciliation Act of 1981 and the Tax Equity and Fiscal Responsibility Act of 1982. Before acting on any of these proposals, the committee will want to consider the viewpoints of a wide variety of participants in the design and delivery of services and financial assistance to citizens. The committee will also hear from the Administration, not only on the fiscal year 1984 proposals, but also on the impact of the fiscal years 1982 and 1983 changes.

## CONCLUSION

I want to assure all interested parties that the Finance Committee will listen to the testimony and carefully evaluate the proposals—always keeping in mind the need to balance the goal of reducing the budget deficit with the need to provide health, income security and necessary social services.

I welcome our witnesses and look forward to hearing their views on the Administration's proposals.

The CHAIRMAN. This morning we begin a series of hearings on spending proposals for programs within the jurisdiction of the Finance Committee. Although the budget process is incomplete, this committee is moving to complete its hearings so we might be prepared for legislative action. Today and tomorrow we will hear testimony from the administration and the public on administration's spending reduction proposals for medicare, medicaid, maternal and child health, and the income security and social service programs under the Social Security Act, such as AFDC, SSI, and child support.

While reductions in entitlement spending may be difficult, the Finance Committee must be ready to do its share to bring down the deficit. Indeed, the record will show that the committee has exceeded its spending reduction targets for the last 2 years. In 1981, a 3-year outlay reduction of $26.7 billion was achieved, and $17.5 billion was cut last year in TEFRA. Already this year the social security amendments have achieved outlay savings of $3 billion in fiscal year 1984, and yet the deficit is projected at $200 billion for the next several years. There is need for restraint in all programs.

The medicare trust fund is, as you all know, rapidly approaching a period of time in which it will no longer have sufficient funds to finance health-care expenditures for the elderly. Under current assumptions, the program will reach this point some time prior to 1988 unless something is done to moderate its growth. I assume we can wait until we have a gun at our head, as we did in social security, or we can start to address those concerns now. It is my view that we ought to start to address the concerns at an early time so we can preserve this very important program without a last-minute rush or a commission of some kind to address it.

No single change is likely to be enough to solve the financing problem, so we are looking at a number of areas. We have been meeting with a number of groups, including physicians, to see how they might be willing to contribute to this problem.

We also have a record, we believe, of a careful, compassionate study of spending reforms in the income security and social services programs. For the past 2 years we have evaluated measures proposed by the administration with the overriding goal of preserving the income security programs while reducing or eliminating unintended and unwarranted benefits. Our guiding principle has been the belief that income security programs should target scarce resources to those most in need, and those who cannot provide for themselves and their families. I am convinced that the reforms voted by this committee, many now in the law, have met that requirement.

The changes proposed by the administration this year are intended to assure that limited Federal and State resources are spent as effectively as possible. The administration believes that these reforms will compliment those made in the Omnibus Budget Reconciliation Act of 1981 and TEFRA of 1982. But before acting on any of these proposals, the committee wants to consider the viewpoints of a wide variety of participants, and that is the purpose of the hearing today.

So I would just assure those who are going to be testifying this morning and tomorrow that we will, as we have done in the past, carefully evaluate the administration's proposals. Some probably have merit. I haven't made any judgment, but I think we understand the need to take a look at all programs. And I would say that we are also taking a look at all the so-called tax preferences and tax expenditures, because it is my view that we should look not only at spending programs but at revenue programs as well.

We have a large number of witnesses today, and I don't want to be less than charitable to all the witnesses who have come long distance. But in the interest of time, I would remind the witnesses that what we hope to do is to make a record. And each witness' statement will be made a part of the record as though given in full. It is my hope that we can summarize the statements and move as quickly as we can to finish the hearing today.

Our first panel is Mr. Carros, executive director, Children's Bureau of Delaware, on behalf of the Child Welfare League; Miss Jane Russell, founder of WAIF; Sandra Crawford, Pennsylvania Public Policy Association of Junior Leagues, New York, N.Y.

I assume, unless there is some other order, we can proceed in the order in which your names were called.

## STATEMENT OF DEMO N. CARROS, EXECUTIVE DIRECTOR, CHILDREN'S BUREAU OF DELAWARE, DOVER, DEL., ON BEHALF OF THE CHILD WELFARE LEAGUE OF AMERICA, INC., WASHINGTON, D.C.

Mr. **Carros**. Thank you, Mr. Chairman. I am Demo Carros. I am executive director of the Children's Bureau of Delaware, which is a private child welfare agency serving dependent and neglected children since 1914. I wish to thank you for this opportunity to testify as you ponder the fiscal year 1984 budget proposals. I am summarizing our testimony.

I am appearing today on behalf of the Child Welfare League of America. The league was established in 1920, and its 400 members and 1,200 affiliates provide adoption services, day care, day treatment, foster care, maternity home care, protective services, residential treatment, and many other types of services to children and their families.

We recognize the need for economic stabilization, especially for families under stress. However, additional cuts in human services will not lead to economic stability, and in the long run will cause increased deficits and human suffering. In fact, cuts made in recent fiscal years are having an impact on services to children and their families, services which are cost effective and which help prevent family dissolution.

I would like to call your attention to Public Law 96-272, the Adoption Assistance and Child Welfare Act, a law which has been jeopardized by funding cutbacks and lack of Federal leadership. Public Law 96-272 represents a comprehensive set of protections, procedures, and services for children and their families by specifically mandating prevention of unnecessary separation of children from their parents, improved quality of care and services to children and their families, and permanency for children through reunification with parents, adoption, or permanent foster care.

Realizing that only by providing alternatives to foster care could the system be reformed, Congress placed new emphasis on child welfare services, and created an adoption assistance subsidy program while maintaining AFDC foster care as an entitlement program for abused, neglected, and dependent children. I believe that the experience of my agency is representative of other agencies throughout this country which are seeking to implement this law. Our agency feels that it is imperative that funding should be at a level to support the provisions of the law in fiscal year 1984. An increase for title IV-B child welfare services from $156 million to $266 million would enable Delaware to implement the law as it was originally intended. It is most important that foster care and adoption assistance remain open-ended entitlements for children at the same time that IV-B is fully funded.

The past 2 years have not seen this kind of child welfare program improvement we had all expected when Public Law 96-272 was passed. The ability to follow through on permanency planning is severely hampered by inadequate funding. The ability to return children to their own homes or move them on to adoption is dependent most of all on the ability of the workers to give a child the attention services and the time necessary to accomplish the case plan.

Presently, our agency is carrying foster care caseloads which should have two additional workers. Our contract for purchase of service with the State only allows us to be reimbursed for a predetermined number of children. We reached that number in April, and for the remaining 2 months we will not be reimbursed for 13 children who need substitute care. This represents a cost to our agency of $43,000.

At this time, the State simply does not have the funds to appropriate funds for that kind of care for their children. The need to provide foster care to these children is related to the economy which has subsequently increased the foster care request.

We emphasize permanent plans for children. We provide services to children in their own homes, and 2 years ago we started a small home-based program, expecting that as fewer children entered foster care, more services should be required for children remaining at home. However, the funding is just not there to support adequate home-base services, and foster care needs have not diminished as expected.

Our funding base for the critical programs is Federal dollars. To date, child welfare services have not fully funded as the law intended. The Title XX Social Service Block Grant was drastically cut by almost $700 million in 1981. For fiscal year 1984, the administration proposes alteration of the reform system which Public Law 96-272 represents. Child welfare training would be consolidated with child welfare services, and funding for both would be only $156.3 million. This proposal means a $3.8 million cut in service's resources by the elimination of a sorely needed training program to train workers.

· Delaying regulations, unclear compliance criteria, and a lack of technical assistance to the States have left the States confused and reluctent to fully utilize and implement this law.

Finally, we realize that the proposals for reduction in medicaid are made in the context of escalating health care cost. We feel it is unjustifiable, however, to restrict health care to children, pregnant women, and mothers when there is no evidence that this reduces health care cost in general, and, in fact, is more expensive to society in the long run.

Thank you for the opportunity.

The CHAIRMAN. Thank you. I think what we may do is just have the entire panel give their statements and then we can ask questions.

Mr. CARROS. Fine.

The CHAIRMAN. Miss Russell.

[The prepared statement of Mr. Carros follows:]

### TESTIMONY OF THE CHILD WELFARE LEAGUE OF AMERICA, INC., PRESENTED BY DEMO N. CARROS, EXECUTIVE DIRECTOR, CHILDREN'S BUREAU OF DELAWARE

The Child Welfare League of America was the first, and continues to be, the only national, not-for-profit, voluntary membership organization which sets standards for child welfare services in the United States and Canada. Our agencies provide a full range of services to children, youth and families. The league is a privately supported organization comprised of 400 child welfare agencies whose efforts are directed to the improvement of care and services for children and their families. League member agencies include religious groups as well as nonsectarian public and private nonprofit agencies. The league also represents 1,200 affiliated child care agencies through our 27 State Child Care Associations. Members and affiliated agencies of the league serve several million children in the United States and Canada and represent over 6,000 volunteer board members and several thousand more direct service volunteers.

We recognize the need for economic stabilization, and thank the committee for having these hearings. However, additional cuts in human service programs will not lead to economic stability, and in the long run will cause increased deficits and human suffering. In fact, cuts made in the recent fiscal years are having an impact on services to children and their families—services which are cost effective and which help prevent family dissolution.

A good example of a critical children's program has been jeopardized by the lack of Federal leadership coupled with funding cutbacks is Public Law 96-272, the Adoption Assistance and Child Welfare Act of 1980.

The Adoption Assistance and Child Welfare Act amended the title IV-B child welfare services and title IV-A foster care programs and created a new title IV-E foster care and adoption assistance program. These amendments include a comprehensive set of protections, procedures, and services for children and their families. Public Law 96-272 specifically mandates: (1) prevention of unnecessary separation of the children from the parent(s); (2) improved quality of care and services to children and their families; and (3) permanency through reunification with parents, adoption, or other permanency planning.

Realizing that only by providing alternatives to foster care could the system be reformed, Congress placed new emphasis on increasing Federal title IV-B Child Welfare Services funds, and created a Federal adoption assistance program. This focused funding on necessary alternatives: family strengthening services and incentives for adoption.

To ensure that alternative services were available, increases in Federal title IV-B Child Welfare Service funds were required on an advanced funding basis, before a national cap on Federal expenditures for AFDC-Foster Care could be imposed. For any fiscal year in which Federal funds appropriated for title IV-B Child Welfare Services are insufficient to trigger a nationwide ceiling on foster care funds, States have the option of operating their foster care program under a State-by-State foster care ceiling based on one of three formulas contained in the law. Under the optional ceiling, States may transfer excess foster care funds from their allotment under title IV-E to the title IV-B child welfare services program, provided that they have the protections and procedures in place which the law requires. Since the title IV-E reimbursement rate is based on the medicaid matching formula—approximately 50 percent—and title IV-B is a 75 percent Federal match, this provision creates a fiscal incentive to States to provide family strengthening services.

For the last two years, Congress has reaffirmed its commitment to P.L. 96-272 by rejecting proposals to include the law in a block grant and reduce its funding. However, the level of title IV-B Child Welfare Services funding envisioned to enable States to implement this crucial child welfare reform bill has been severely restrained. At the same time, the major Federal funding source for the full range of social services, the title XX program—the basic "service floor" for children, youth, families and individuals—was drastically cut by almost $700 million in 1981 under the Omnibus Budget Reconciliation Act (OBRA). Further, OBRA title XX amendments eliminated the future annual incremental increases in the title XX program legislated in Public Law 96-272. this "pulled the rug out from under Public Law 96-272" as States struggled to cope with their current level of need for services and State budget cuts, while lacking the additional resources to implement the new reforms.

In addition to cuts in human service programs, Public Law 96-272 has been hampered by administration proposals which would have repealed the law and turned it into a block grant (fiscal year 1982 and 1983) and the new fiscal year 1984 proposals which would alter the complex system of funding for reform.

For fiscal year 1984 the administration proposes alteration of the complex system of funding and reform in Public Law 96-272. Specific changes include consolidation of the child welfare training funds, awarded on a discretionary basis by the Department of Health and Human Services, with the child welfare services program. Funding for both these programs would be only $156.3 million. Child welfare training was funded at $3.8 million in fiscal year 1983. This proposal would mean a $3.8 million cut in service resources or elimination of the small training program to develop qualified child welfare workers. Public Law 96-272 envisioned funding of $266 million for Child Welfare Services by fiscal year 1984 and seperate funding for training. The administration also proposes to increase funds for foster care up to the $440 million, consistent with the fiscal year 1984 projection by the Congressional Budget Office (CBO) and the Office of Management and Budget (OMB). However, the administration would then permanently cap foster care funds at the $440 million level without regard to the Public Law 96-272 mandates and reform incentives. CBO estimates that future expenditures for AFDC-Foster Care would be $480 million in fiscal year 1985; $525 million in fiscal year 1986; $573 million in fiscal year 1987; and $627 million in fiscal year 1988. Public Law 96-272 imposed a fiscal year 1984 national cap on foster care only when the funding for Child Welfare Services reached $266 million and was forward-funded. The law is not fully implemented, and it would be arbitrary and capricious to accept the administration proposal to limit funding for vulnerable children in need of foster care services when alternatives for their protection are not sufficiently available.

The administration does request the full authorized amount for the title XX Social Services Block Grant, but assumes consolidation of the activities of the Community Services Block Grant (CSBG) and Work Incentives (WIN) program into the title XX block grant without additional money. This consolidation would represent more than a 25-percent cut to the programs. Prior to OBRA, Public Law 96-272 authorized Title XX at $3.2 billion, plus $75 million in training and $16.1 million in social service funds for the territories by fiscal year 1984. So the loss for child welfare reform is severe.

Implementation of the reform provisions has been hampered by funding cutbacks as well as the administration's delay in publishing regulations for Public Law 96-272 in final form, which caused extensive confusion among the States. When the regulations were finally published 3 years after the passage of the act, they continued to thwart the intent of the law by permitting States to define and interpret the reform measures, decreasing the ability to measure the success of implementation. For instance, even minimum components defining what would constitute the reunification and preventive services programs are left totally up to the States. It is, therefore, incumbent upon Congress to take leadership in preserving the integrity of the law and authorize and appropriate the recommended funding levels anticipated in Public Law 96–272 and title XX to assure implementation.

Without the money for full implementation, dangerous situations are developing at the State level. In order in reduce the number of children in foster care, children are being returned home without the necessary protective reunification services for children in their own homes. This is a direct consequence of inadequate funding for title IV–B and the title XX Social Services Block Grant. Examples of this trend have been cited by a Child Welfare League agency is Philadelpia, Pennsylvania:

A boy, age 10, and his sister, age 8, recently returned from placement to a chronically psychotic mother, against medical advice, and to a severely debilitated father in an advanced stage of alcoholism, to live in a home that is unfit for human habitation and is frequented by drunk and disorderly adults.

A 7-year-old regressed to the level of an infant within 6 weeks following discharge from placement and return to a home with a long history of child abuse, including second degree burns and profound neglect.

Newborn, premature twins of a mother under protective supervision for her children ages 7, 2½, and 1 were sent home. In 3 months, these newborns required emergency placement after hospital treatment for severe weight loss due to irregular feedings.

We know from our experience with agencies that, with adequate funding of Public Law 96–272 and title XX, such situations can be prevented. The law has clearly shifted the focus of services to families. There has been a large growth in in-home services. Residential facilities work to strengthen families for reunification by developing a continuum of services, including aftercare to maintain needed support to families once children are returned. It is important to understand what in fact is provided to children for whom permanency is the goal. We have many child welfare agencies which we could use as examples, but we have chosen one, the Whaley Home in Flint, Michigan, to provide the Committee with a picture of the services which Public Law 96–272 and title XX provide.

From the moment children arrive at Whaley Children's Center, they are headed home. Most of the children have been removed from their homes because of chaotic, abusive or neglectful family situations and the child's problems which are a result of these situations. Sixty percent of the children are permanent wards of the State, and another 40 percent still have families with whom they may eventually be reunited. In either case, all of Whaley's efforts are toward placing the child permanently in a family. The permanent placement is achieving by a variety of integrated programs:

*Residential treatment.*—a therapeutic setting of intensity for an average stay of about six months;

*Community group treatment homes.*—for the child ready to move from the residential center into a less structured community based setting;

*Pre-vocational adolescent program.*—for older youths (12–17 years old) who cannot function well within a family but who are capable of learning the skills needed eventually to live and work within the community, this program serves youths from the group homes;

*Residential and day treatment school.*—an on-grounds school serves the children from the residential and group home care, as well as children who are living in their own homes but who need greater special education services than are offered in local community schools;

*Treatment foster family program.*—a specially trained foster family is available when the child is ready to move into a family setting. These families are screened and intensively trained and provide the final bridge between out-of-home care and permanent placement in an adoptive family or a return home;

*Specialized adoption program.*—a specialized program to find particularly appropriate adoptive families for children eligible for adoption. The prospective family (which is often the child's treatment family) is trained to help the child and continues to receive support from the Whaley staff as well as a support group of fellow adoptive families;

*Support for the child's original family.*—Includes meetings with parents of children in placement, support groups for parents, and joint planning for the child's treatment;

*Aftercare services.*—Even when returned home or adopted, the child and family continue to need aftercare support to assist the child in the readjustment to living in a family or to help the child who is experiencing temporary problems in the family setting. This program ensures continuation of a positive outcome.

The Child Welfare League worked for years to achieve passage of this law and we have continued to work for the last three years to implement it. We know it is a complex law, and we know that enormous progress has been made toward implementation in spite of the confusion in the States as to regulations, funding, and criteria for compliance. Some examples from the States illustrate this fact:

Kansas reported that custody cases are being closed at an increased rate as permanency planning concepts for children have been implemented. In the first six months of fiscal year 1982, 2,095 children were released from custody as compared with 2,952 closings in all of fiscal year 1980. Data available in the child tracking system shows that children are remaining in the system for a shorter period of time. The family support worker program has demonstrated a 48 percent savings, and in cases where children absolutely would have been removed from their homes, a saving of $111,000.

Rhode Island reports a large increase in the number of children legally free for adoption, as the law has emphasized the termination of parental rights, thereby acting to place many more children in permanent families.

New Jersey has set up a system of permanency planning and review which has reduced the foster care case load over three years from 8,000 down to 6,500.

Oregon has contained its case loads and put more money into extensive family services; follow up shows that 75 percent of the families are still intact. There has also been an increase in the number of adoptive placements and a 32 percent reduction in case loads.

Illinois is an example of a State which was already moving toward the goal of permanency for all children. The passage of Public Law 96-272 hastened this movement, as illustrated by a several hundred percent increase in the number of adoptions, a quantitative increase in case plans, and a decrease in the number of children in substitute care.

Louisiana is an example of a State which took Public Law 96-272 and continued to reorganize the child welfare service delivery system. The law legitimated efforts that had already begun and assisted movement of the children with both the blueprint and the Federal dollars. Case loads have stopped increasing at the previous rate.

These examples indicate that some of the hopes and dreams of Public Law 96-272 are being realized. We would like to highlight for the Committee some of the remaining issues existing relative to the parts of this law:

*Adoption Assistance.*—The 1978 study, "Where are The Children?" by Shyne and Shroeder, found that the single most important factor in the placement of special needs children is the adoption subsidy. That is still true today. The States are not yet fully utilizing the IV-E adoption subsidy because they do not understand who is eligible, and they need more guidance than the final regulations which were premulgated by HHS on May 23, 1983 (45 CFR Parts 1355, 1356, 1357, and 1392).

We know from a study by Seeling in the Family Law Journal that on the national average, placing children in an adoptive family with subsidy costs 37 percent less than maintaining a child in foster care. The reduction ranges from a low of 19 percent to a high of 60 percent. We need time to continue the implementation of this important component of Public Law 96-272—time to educate or re-educate legislators and administrators on the cost benefits of adoption subsidy, the concept that the child, not the adoptive parent, is the recipient of the subsidy, and the types of children who are eligible for Federal financial participation under Public Law 96-272.

*Title IV-E, Foster care.*—The 1980 National Survey of Residential Group Care Facilities for Children and Youth (Pappenfort, Young and Dore), shows that from 1965 to 1981, residential facilities in this country became smaller, and that by 1980, 57 percent of all residential facilities were serving 20 or fewer children. The study finds that, "In the child welfare stream, the most notable change between 1965 and 1981 was the relative decrease in the proportion of residential group care facilities for dependent neglected and abused children and youth." We are clearly seeing the decline of the large warehouses for children and youth who must be in substitute care. The League knows that substitute care continues to be appropriate for some children who cannot be cared for adequately by their families. In 1980, the League undertook a study of the U.S. foster care population. The purpose was to obtain data which could serve as a baseline for evaluation of Public Law 96-272. From a 47 State survey, we estimated some 263,208 children in public foster care. We have reason to believe that this is an accurate figure of today's population of children in public substitute care. We want to stress that at the time of our study, there was great variation in the type of information collected, and we know that there are many more children who are not part of the public social service agency caseload. For these reasons, we believe accurate data collection is essential, and support continued emphasis on the state-wide inventory of children in foster care and child-tracking systems.

The reasons for this continued level in public foster care from 1980 to 1983 are:

Increased stress on families with cuts in entitlement programs and high unemployment;

Greater reporting of child abuse and neglect; and,

Implementation of, and social work "technology" for family support work is still in the infancy stages.

Until such time as we can fully implement the preventive and reunification services and until we have provided more technical assistance to the States with these new service systems, we can expect the foster care caseload to be fairly static. This fact demands the continuation of the system of Public Law 96-272 which prohibits the capping of Title IV-E until the protections of the law are in place, and until Title IV-B has been fully funded. We also believe that the continuation of Title IV-E reimbursement for voluntary placements is important in these times of family stress. We urge support for H.R. 2354 which makes permanent the temporary provisions for dependent children voluntarily placed in foster care.

*Title IV-B, Child welfare services.*—In the past few years, there has been a new recognition of biological families at risk. We are to date behind in our family treatment technology. There is no single verifiable treatment model, but we know that various family support services do work. There are a large number of chronically chaotic families today, and a proportion of them will be stabilized by preventive and reunification services, but a number of them will not. And for the children of these families, substitute care and adoption are important.

The League believes that the emphasis which Public Law 96-272 placed on permanency for children is serving to revitalize child welfare services in this country, and to put those services in a family context. We cannot abandon those agencies attempting to provide these services, we cannot expect them to perform miracles, and we cannot punish them for trying to help the families that are in stress in this country. We can however help them by funding child welfare services at the level which is called for by the law—$266 million for fiscal year 1984, and by maintaining a separate Child Welfare Training program which can assist in the training of workers to carry out the work of this law. Our agencies report that they cannot find workers coming out of social work schools who are equipped to work with children, or to carry out the kinds of family work necessitated by this law. We also suggest the consolidated resource centers could be of help in this area by bringing together the people from the States and providing them with technical assistance to move this law along towards full implementation.

All of our observations and concerns about the three tiers of this law—Title IV-E Adoption Assistance, Title IV-E Foster Care, and Title IV-B Child Welfare Services—can be addressed by:

Full funding for Public Law 96-272, with $266 million for Title IV-B and continued open-ended entitlement funding for Title IV-E;

A strong commitment to the law from the Department of Health and Human Services with clear expectations, more specific guidance than is provided in the current regulations, and more technical assistance to States in the implementation;

A continued emphasis on Child Welfare Training by maintaining this discrete program dedicated to the development of qualified child welfare workers, funded at $3.8 million; and

Continued support for Title XX as a separate block grant, funded at $2.8 billion for fiscal year 1984, an increase of $300 million.

### AID TO FAMILIES WITH DEPENDENT CHILDREN

While we have discussed the stabilization of families in terms of Public Law 96-272, we would like to point out that there is a primary preventive measure which the Congress can take to ensure that fewer and fewer children enter the child welfare system, and that is to maintain and strengthen the almost 50-year-old Aid to Families with Dependent Children (AFDC) program. The primary purpose of AFDC is to keep children in their own homes by giving first aid to children deprived of parental financial support due to the absence, disability, death, or, in some instances, unemployment of their parents. AFDC has become a dirty word conjuring up visions of enormous outlays of taxpayers' money to a bunch of adult dead beats who are unwilling to work for their daily bread.

In reality, AFDC is one of the very smallest Federal programs. More importantly, it is a program for destitute children. Almost 70 percent of all AFDC recipients are children. Adults receive AFDC benefits only as caretakers of children. Also contrary to popular beliefs, the benefits are not enormous. I invite members of the Committee to look at the attached list of maximum AFDC benefits for a family of four in each of your States and try to imagine what it would be like to feed, clothe, and shelter a family of four on such a budget in your home town. I suspect that you will conclude, as I do, that this would be no "free ride." It is a bare essentials program, offering little inducement to remaining on welfare for any longer than absolutely necessary.

For 3.5 million families, it ws adjudged absolutely necessary for some period of time last year. Approximately 81 percent of these were female-headed families in which more than 36 percent of the children were under age 6 and another 49 percent were between 6 and 14 years old. These children remained in their own homes with their mothers or close relatives at a fraction of the emotional and financial cost of the journey through out-of-home care to possible eventual permanent placement with another family.

In 1981, at the Administration's recommendation, Congress enacted a long list of amendments to the AFDC law, all directed to substantial reductions in AFDC eligibility and benefits and projected savings in Federal and State expenditures. In April of this year, the Department of Health and Human Services released the results of a study, Evaluation of the 1981 AFDC Amendments, prepared by the Research Triangle Institute under contract to the Department. The Department says the report proves that the 1981 amendments were successful in reforming the AFDC program, particularly with respect to those working poor recipients who lost benefits as a result of the amendments but did not subsequently return to the program.

These findings are so totally at odds with what the Child Welfare League is hearing from its members around the country that I would like to make a few comments on the Research Triangle report as well as share a few of the observations of both public and private nonprofit Child Welfare League member agencies. As you may recall, the explanation for the failure to achieve the Administration's projected $1 billion in savings in fiscal year 1982 was that States were slow to implement the mandated changes. This is understandable, since the changes were many and complex; the lead time was only one month; and State laws and regulations had to be amended to accommodate the changes, not to mention the time required to reprogram State and local procedures and retrain personnel. The fact remains that the Research Triangle study compared data on fiscal year 1981 AFDC recipients with case records of fiscal year 1982 recipients, and there is considerable room for doubt that the OBRA changes were sufficiently operative in fiscal year 1982 to give a significant reading on the effects of the changes.

I would point to the fact that there are at least 33 studies in progress by leading universities and research organizations that address the issue of the impact of the Federal policy changes on AFDC recipients (see The Impact of Federal Budget Cuts on AFDC Recipients, A Compendium of Studies, The Center for the Study of Social Policy, 236 Massachusetts Avenue N.E., Washington, D.C. 20002, for descriptions of these studies), and the present consensus is that the data is not yet available. I wish it were. The chief researcher for the Research Triangle study says that "we can make pretty confident statements about those dropped from the rolls and those who have returned but we cannot say how people have coped." (National Journal, May 7, 1983, p. 976). It seems to me that when we are talking about destitute children it is pretty important to know how their families have coped.

This is particularly important because we don't seem to know what happened to the more destitute of those working families removed from the rolls. The Research Triangle report says the families removed from the rolls who did not return to the AFDC program were predominantly the higher earners with more education. One stated goal of the 1981 amendments was to target benefits more directly to those most in need. Surely the lower earners and the less educated are more in need. Additionally, I would like to point out that there has been no increase in benefits to either non-earners or to low wage earners remaining on the rolls. Len Schneiderman of the Brookings Institution has analyzed the Research Triangle report and finds that, for FY 1982, there is evidence of a decline in average benefits to non-earners; an increase in the probability of case closings for non-earners; and reductions in re-openings of closed cases which suggests a pattern of reduced use of or access to benefits for non-earners, presumably the most needy.

And now I would like to share with you reports from Child Welfare League member agencies. These are mostly front line experiences and impressions, but I think it is important for you to hear them:

"We've had a rash of young mothers wanting us to take their children."

"The AFDC population in our State went down for awhile but is rising again as of the fall of 1983."

"Families are coming to town looking for work and living in their cars. When they don't find work, they bring their kids to our agency and ask us to keep the kids in temporary foster care because they have no money to feed them and they don't qualify for AFDC help."

"The AFDC caseload decreased for about six months and began increasing thereafter."

"We closed 6,208 AFDC cases and were able to follow 6,012 of these for the next ten months. For each month following implementation of the four months limit on earning disregards, the cost benefit of working was negative. Over 50 percent were back on the rolls within three and a half months.

"The guardian ad litem for two children who were former AFDC recipients became appropriately concerned that the children were not receiving prescribed medical care, so he took the case to court. Without AFDC eligibility for Medicaid for the children, the mother was only sporadically able to pay for the medical care although she was trying. The court hearing tipped the balance for her. She gave up, and now the children are in public care."

"An AFDC-UP family with a father who was laid off were living in a condemned house because they had no money for rent. The city insisted they leave. They lost AFDC-UP benefits. They had no home for the children. We could have salvaged that family with just a little bit of assistance, but there were no funds."

Those of us who are public and private nonprofit children's services agencies are seeing too many families falling apart and too many children in truly deprived circumstances not to want to ask you to reconsider some of your changes in the AFDC program. On behalf of the Child Welfare League I ask you to give serious thought to repealing the most restrictive of the 1981 amendments. And I certainly hope you will not adopt the additional restrictions proposed by the Administration in the fiscal year 1984 budget for AFDC, including the Administration proposal to repeal the Work Incentive (WIN) program which is the only work program which acknowledges the need for supportive services if AFDC mothers are to move into gainful employment. The already overextended and underfunded title XX program cannot absorb these service functions.

## MEDICAID

Finally, we wish to address the Administration's proposals for Medicaid. The Administration is proposing further cuts in the Medicaid program to reduce Federal expenditures by $300 million in fiscal year 1984 and $1.9 billion over the period fiscal years 1984-86. These reductions would be in addition to Medicaid cuts already enacted in 1981 and 1982 which reduce Federal Medicaid spending by $4.3 billion over the period fiscal years 1982-85.

While we understand that this is in the context of a 15 percent per year rise in health care costs generally, the Child Welfare League believes that it would make more sense to work on broader solutions to the problem of rising health care costs. Cuts in medical care for the poor have had no effect on the general problem so far. And we feel it is unjustifiable to restrict health care for poor children when there is no evidence that this reduces health care costs in general. With the addition of large numbers of families losing health coverage due to unemployment, we have reason to be exceedingly concerned for the health of the nation's less than affluent children. We urge you not to make further cuts in the Medicaid program which is the only health care resource for a least 20 percent of the nation's children living in poverty.

### STANDARD OF NEED AND MAXIMUM AFDC BENEFITS IN SENATE FINANCE COMMITTEE STATES, JANUARY 1983

[Family of 4 (70 percent children)

| | Per month | |
|---|---|---|
| | Standard of need [1] | Maximum benefit |
| Kansas | $411 | $411 |
| Oregon | 409 | 409 |
| Delaware | 312 | 312 |

STANDARD OF NEED AND MAXIMUM AFDC BENEFITS IN SENATE FINANCE COMMITTEE STATES, JANUARY 1983—Continued

[Family of 4 (70 percent children)]

| | Per month | |
|---|---|---|
| | Standard of need [1] | Maximum benefit |
| Missouri | 365 | 305 |
| Rhode Island | [2] 520 | [2] 520 |
| | [3] 420 | [3] 420 |
| Pennsylvania | 415 | 415 |
| Wyoming | 390 | 390 |
| Minnesota | 520 | 520 |
| Colorado | 470 | 387 |
| Idaho | 627 | 345 |
| Iowa | 482 | 419 |
| Louisiana | 620 | 234 |
| Texas | 201 | 140 |
| Hawaii | 546 | 546 |
| New York | 602 | 602 |
| | [4] 515 | [4] 515 |
| Montana | 513 | 425 |
| Oklahoma | 349 | 349 |
| New Jersey | 414 | 414 |
| Maine | 564 | 408 |
| Arkansas | 273 | 164 |

[1] Standard of Need is what each State determines is essential.
[2] Per winter month.
[3] Per summer month.
[4] New York City.

Source: Congressional Research Service Survey.

## STATEMENT OF MISS JANE RUSSELL, SEDONA, ARIZ., FOUNDER, WAIF, NEW YORK, N.Y.

Miss Russell. Good morning, Mr. Chairman, and members of the committee. I thank you for the privilege of appearing before you today. I am Jane Russell. I am an actress, I have adopted three children, and have been a child advocate for 30 years.

In 1955, I founded WAIF, a nonprofit organization dedicated to finding permanent and loving families for America's homeless children. WAIF has members in every State across the country and our programs are completely financed by private donations.

I am here today to speak for half a million children who are growing up in the limbo of foster care, and about Public Law 96-272, a 3-year-old law which performs miracles but still has not been fully enacted.

Several months ago I went to a hearing of the foster care review board in my home State of Arizona. All States are supposed to have foster care review boards, but do not. Daniel was the first case we reviewed. He had been lost in the foster care system for 5 years. There was no record of his whereabouts; there was no social worker assigned to his case.

Karen is 13. In the past 11 years she has lived in two group homes who had seven foster families. She was tired of coming home from school and wondering whether she would be greeted by her social worker and by a box packed with all of her belongings in it because it was time to move once more. Karen's parents had disappeared and no one had brought her to court to free her for adoption.

Then there was the mother of seven children who lived in seven different foster family homes across the State. She had emotional problems and had turned to alcohol. She desparately wanted her kids and her kids wanted to be with her. In fact, they kept running away from their foster homes and they would run right back to mom. These kids represent my concern for our foster care and adoption systems.

Fortunately, there are happy endings to these stories. Daniel has been found and has been adopted by his foster parents. Karen was freed from adoption and moved to her new family. Counseling and rehabilitation have been provided in the third case. The seven children have returned home and $70,000 a year has been saved in foster care payments.

These happy endings are the result of the Adoption Assistance and Child Welfare Act of 1980, Public Law 96-272. It is a miraculous new law which works for kids, for society and for the taxpayer. For all too many years we threw money in the general direction of the problem, and wondered why it wasn't working. Public Law 96-272 targets the errors of the system and provides the necessary reforms. That has already been proven when these programs were tested in Oregon, Los Angeles County, Arizona, and Illinois. I have never before encountered a program which works so well for kids and so cost effectively for government. But it requires the investment of funds up front. We must invest in these reforms now to see the long-term savings in lives and tax dollars.

I have come to Washington four times in 2 years to fight for the life of Public Law 96-272 because this law fights for the lives of our children. Foster care funds are Uncle Sam's babysitting bill. Foster care is a necessary service but, like babysitting, foster care should only be for short periods of time. Permanent families are a much better answer.

WAIF sponsors adoption parties called "Project Adopt." We work in conjunction with private and public agencies to find families for children with special needs. Our first 7 events have resulted in the adoption of 146 children. Durrell found a family at age 16. He lived in 17 foster homes, 3 group homes, and an institution. Another boy, Eric, was 14, mildly retarded, sight impaired and handicapped by cerebral palsy. He has lots of problems but he is no longer homeless.

Susan is 14, profoundly retarded, and was considered unadoptable. Her social worker brought her along just to give her a day away from the institution. Six weeks later, Susan was living with her new adoptive family. These adoptions would not have been possible without Public Law 96-272 which frees children for adoption and provides a subsidy to help with the cost of medical care for special needs children.

We have 50 different State adoption laws and some of them are 50 years behind the times. The result is that 500,000 children grow up in limbo. The States want to help children, but they need help in doing it effectively. We must insure that our children's lives are not wasted and that our tax dollars are spent wisely.

If Public Law 96-272 is fully implemented, we will see long term savings. It is a lot cheaper to return children home to a restrengthened family or to place them in adoption than it is to keep them in foster care. It cost between $6,000 and $25,000 to keep a child in the system for 1 year. In 1981, Los Angeles County saved—this is just Los Angeles County—$1,600,000 in foster care payments by placing 503 children for adoption. If these children had remained in foster care to age 18, it would have cost in excess of $19 million.

We must not let homeless children be caught in the debate of the Federal deficit.

As you deliberate, I urge you to budget wisely for these children. You are their only hope. I ask you to consider the following recommendations:

First. Title IV-B: Child welfare services should be fully funded at $266 million to continue the necessary reforms, and to begin the preplacement preventive services. Child welfare training should be continued as a separate program.

Second. The title IV-E foster care program should remain an open-ended individual entitlement program for needy children.

Third. Adoption assistance should remain an open-ended individual entitlement program for AFDC and SSI eligible special needs children, with sufficient funding to allow all States to put mandated programs in place this year.

And last, maintain title XX as a separate entitlement program to the States with an increased authorized ceiling of $2.8 billion as assumed by the House budget for fiscal year 1984.

I thank you for your consideration and the opportunity to speak with you today.

The CHAIRMAN. Thank you. Miss Crawford.

[The prepared written statement of Miss Russell follows:]

### TESTIMONY OF MISS JANE RUSSELL OF WAIF, INC.

Good morning Mr. Chairman and members of the committee. I thank you for the privilege of appearing before you today. My name is Jane Russell; I am an actress; I have adopted three children; and I have been a child advocate for the past 30 years when I first testified before Congress on behalf of homeless children. In 1955 I found WAIF, an organization dedicated to finding permanent and loving families for America's homeless children. I serve on the national board of directors of WAIF and have previously served on the California State Adoption Commission.

WAIF is a national non-profit, voluntary organization, with members in every State across the country. WAIF is the private sector. We are concerned volunteers and our programs are completely financed by private donations. I am not here to seek funds for or to protect WAIF's budget. Our advocacy is a pure attempt to provide a voice for voteless children.

I appear here today to speak for a half million children who are growing up in the limbo of foster care. Five hundred thousand children who are denied the opportunity to grow up in a nurturing and permanent family. They are truly the victims of a child welfare system headed in the wrong direction.

Several months ago I went to a hearing of the foster care review board in my home State of Arizona. The first case that the volunteer board members reviewed was that of Daniel. We spent an hour and a half looking at the bits and pieces that made up Daniel's case record. The truth is that Daniel has been lost in the foster care system for five years. There is no record of his whereabouts and there is no social worker assigned to his case. There are only 1,500 kids in the foster care system in Arizona. I can't imagine what is happening to children from high population areas where many thousands of children live in foster care in just one city.

We then met Karen who is 13 years old and has been in the foster care system for 11 years. During that time she has lived in two group homes and with seven different foster families. Karen said she was tired of the system. She's tired of coming home from school and wondering whether she will be greeted by her social worker and by a box packed with all of her belongings because it's time to move once more. Karen wants to know why she can't come home from school like all the other kids and know that she's living with her own family and that they want her and love her. No one knows where Karen's parents are and no one has brought Karen to court to free her for adoption.

Then there was the mother of seven children who lived with seven different foster families all across the State. The mother has emotional problems and has turned to alcohol. She desperately wants her kids and her kids want to be with her. In fact, her kids keep running away from their foster homes and, when they run away, they run right back to their mother. These kids histories represent my concern for our foster care and adoption systems.

Fortunately, there are happy endings to these stories. Daniel has been found and has now been adopted by his foster parents. Karen was relinquished for adoption and will move in with her new family this month. Counseling has been provided in the third case and the mother has been rehabilitated. He seven children have returned home; the family has been saved and the taxpayers have saved approximately $70,000 a year in foster care payments.

The resolution of these cases is a result of the Adoption Assistance and Child Welfare Act of 1980, Public Law 96-272. It is a miraculous new law which works for kids, works for society and works for the taxpayer. I'm here today to plead with you to preserve this legislation and maintain the maximum allowable funding as well as restoration of title XX funds which support its programs.

This is the fourth time in 2 years that I have come to Washington to meet with Senators and Congressmen. Although the law was enacted on June 17, 1980, there have been numerous attempts to fold it into a block grant. When it became clear that the Congress would continue to support this legislation, the administration put the implementing regulations on hold for nearly three years. Those regulations were finally published on May 23rd, 1983. Unfortunately, they fall far short of the specificity needed to implement the programs effectively. They do not clearly define structure of service or program accountability.

We must stop throwing good money after bad. For all too many years we have been throwing money in the general direction of the problem and then wonder why it's not working. Public Law 96-272 will make it work. It will target the errors of the system and provide the necessary reforms. That's already been proven when these programs have been tested in areas such as Oregon, Los Angeles County, Arizona and Illinois. In the 30 years that I have worked in this field, I have never before encountered a program which works so well for kids and so cost effectively for Government. But it requires the investment of funds upfront. We must invest in the systematic reform now to see the long-term savings in lives and tax dollars.

And so I come to Washington once again to fight for the life of Public Law 96-272 because this law fights for the lives of our children. Foster care funds are Uncle Sam's baby sitting bill. Foster care is a very necessary service and most foster parents are amongst the most devoted people in the country. But like baby sitting, foster care is just fine for short periods of time. Real parents and permanent families are a lot better.

With private funds, WAIF has recently begun to sponsor a series of adoption parties called project adopt. We work in conjunction with both private and public agencies across the country to find adoptive families for children with special needs. Our first seven project adopt events have resulted in the placement of 146 children. Durrell found a family at age 16. Prior to his adoption, he had lived in 17 foster homes, three group homes and an institution. Eric is 14 years old, is mildly retarded, sight impaired and handicapped by cerebral palsy. Eric has lots of problems but he is no longer homeless. Susan is 14 years old, profoundly retarded and was considered unadoptable. Her social worker brought her to our project adopt event just to give her a day away from the institution. Six weeks later, Susan was living with her new adoptive family. John, Stephen and Jimmy are three brothers whose mother had died of cancer and whose father left them locked alone in their apartment for two weeks. Their father has disappeared but Jimmy, Stephen and Johnny have found a new family to call their own.

I dare say than none of these adoptions would have become a reality without the programs of Public Law 96-272, for these programs free children for adoption and provide a subsidy to help with the extraordinary cost of medical care and maintenance for special needs children.

We must not let homeless children be caught in the debate of the Federal deficit. Their needs are too great and their futures are in our hands. We must act wisely. I believe that the States want to help children but they just need help in doing it effectively. We currently have 50 different State adoption laws and some of them are at least 50 years behind the times. The result is that 500,000 American children grow up in the limbo of foster care without the love and security of a permanent family. We must ensure that our children's lives are not wasted and that our tax dollars are spent effectively.

I agree totally with Senator Dole that, as we work to reduce the budget's deficit that we must place primary emphasis on spending reductions. If PL 96-272 is fully implemented we will see long-term savings. It is a lot cheaper to either return children to a restrengthened biological family or to place them in adoption than it is to continue them in an outmoded, ineffective foster care system. It costs between six and twenty-five thousand dollars to keep a child in the system for one year. In 1981, Los Angeles County saved $1,600,000 in foster care payments by placing 503 children for adoption. If these 503 children had remained in foster care to age 18, the foster care payments would have totaled in excess of nineteen million dollars. I am talking not only about humanity, but about wise and effective budgeting.

As you deliberate, I urge you to budget wisely for these children. You are their only hope. Specifically, I ask you to consider the following recommendations:

Title IV-B: Child welfare services should be fully funded at $266 million to continue the necessary reforms in the child welfare system, and to begin the preplacement preventive services. Child welfare training should be continued as a separate discretionary program.

Title IV-E: 1. The title IV-E foster care program should remain an open-ended individual entitlement program for needy children. The specific amounts needed to fully meet the program's requirements should be made available. 2. Adoption assistance should remain an open-ended individual entitlement program for AFDC and SSI eligible special needs children with sufficient funding to allow the remaining States and jurisdictions to put mandated programs in place this year.

Title XX: Maintain title XX as a separate identifiable Federal entitlement program to the States, with an increased authorized ceiling of $2.8 billion as assumed by the House budget for fiscal year 1984.

I thank you for the opportunity to speak with you today.

## STATEMENT OF MISS SANDRA CRAWFORD, GLADWYNE, PA., PUBLIC POLICY CHAIRMAN, ASSOCIATION OF JUNIOR LEAGUES, INC., NEW YORK, N.Y.

Miss **Crawford**. Thank you, Mr. Chairman. My name is Sandy Crawford. I am the past president of the Junior League of Philadelphia and I am currently on the board of directors and chairman of the Public Policy Committee of the Association of Junior Leagues. The Association of Junior Leagues is a women's international organization with 243 individual leagues in the United States representing more than 148,000 members.

The Junior League's history in providing services to children is a very long one. It began when the first league was founded in New York City in 1901.

I appreciate the opportunity to appear today and to express our concern about the administration's spending proposals for programs that are under the jurisdiction of the Finance Committee. In the last 2 years, two representative of the Association of Junior Leagues have spoken to this committee in support of the Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272) and adequate funding for the title XX, Social Services Block Grant. Fortunately, Congress listened to the pleas of child advocates to save Public Law 96-272, and last year they refused to make further cuts in the title XX, Social Services Block Grant.

I have submitted written testimony and I will summarize it.

The association opposes further reductions in the title XX, Social Services Block Grant. As this committee is aware, this program provides the basic funding for a variety of critical services for all of our communities. The Social Services Block Grant was cut severely by the Omnibus Budget Reconciliation Act of 1980 which reduced the funding level from $3.3 billion to $2.5 billion for fiscal year 1984.

Most States now use all available Social Services Block Grant funds, and further cuts would be at the expense of our poorest citizens.

Recognizing the need for increased assistance, last March Congress provided an additional $225 million for the title XX, Social Services Block Grant as part of the Emergency Jobs legislation. Now the administration is proposing to undo this action, proposing to reduce the funding level for fiscal year 1984. The administration also is requesting repeal of the Community Services Block Grant, and to use funds from the Social Service Block Grant to fund Communities Social Block Grant Programs. We urge this committee to resist this move that would undercut programs to help women, children, and the elderly.

In fact, we urge increasing the funding level of the title XX, Social Services Block Grant to $2.8 billion for fiscal year 1984 in line with the jobs bill legislation originally approved by the Senate. The need is to increase, not decrease, the funding level provided by the jobs bill.

We base our recommendations to this committee on the reports from Junior Leagues across the country regarding the needs of their communities and their requests for our assistance to meet these needs. Harsh realities of unmet needs are being discovered by leagues and communities all across the United States. One of the programs that many of our leagues are involved in is Child Watch, a citizen monitoring effort.

In Wichita, Kans., the Child Watch project reports that parents who need and cannot find inexpensive day care, often choose to use less desirable methods. For example, an 8-year-old was left to watch his 3-year-old sibling. Another woman who could not get care left her children, ages 3 and 4, in a car in the parking lot while she was at work. In Onondaga County, in New York, the demand for child care was up, but the levels of eligibility for title XX block grant funding was lowered, and most women could not get child care, even though they were employed.

There are examples of need for child care in my own community in Philadelphia, where many parents are unable to afford the fees set by the sliding fee scale, and the agencies have been forced to drop these children from the rolls.

Also social service staff is overburdened in regard to screening and training foster parents. In Philadelphia, I feel I can draw conclusions from the fact that overburdened workers with high case loads seem to run out of time for training foster parents. There were six cases in Philadelphia last year where foster parents abused the children in their care.

Also of great importance to the association is the Adoption Assistance and Child Welfare Act, Public Law 96-272. It is a priority of the association. Over the last 2 years, the administration sought to restructure the Adoption Assistance and Child Welfare Act and to place it in a block grant with reduced funds. The association worked extensively for the passage of this legislation. We still believe that it is in the children's best interests to keep the structure that was created by that law. It was designed to reform the child welfare system, providing fiscal incentives for States to redirect services from out of home care to providing services to help keep families together as well as to reunite separated families.

The administration's proposal would seriously alter the intent of the legislation by putting a cap on foster care without providing additional funds for preventive and reunification services. To do this might endanger the lives of many children. And, in fact, there are many cases where with the deteriorating economic situation, child abuse is increasing, and there is a greater and greater need for more children in foster care. This has been cited not only in my own city of Philadelphia, but in many other cities.

Parents are also placing their own children because they cannot provide food and shelter for them. And, again, more children are in the system.

We believe it is essential to the welfare of children that the structure of Public Law 96-272 be preserved so that States will be encouraged to move ahead with the long overdue reforms that it mandate.

In conclusion, we urge the Finance Committee to continue its leadership in protecting social service programs for children and their families by maintaining Public Law 96-272 and by raising the funding level for the title XX, Social Services Block Grant.

Thank you very much for giving me this opportunity to appear on behalf of the Association of Junior Leagues.

The Chairman. Thank you.

[The prepared written statement of Miss Crawford follows:]

## TESTIMONY OF THE ASSOCIATION OF JUNIOR LEAGUES, INC., PRESENTED BY SANDRA CRAWFORD, PUBLIC POLICY CHAIRMAN, THE ASSOCIATION OF JUNIOR LEAGUES, INC.

I am Sandra Crawford of Gladwyne, Pennsylvania, a past president of the Junior League of Philadelphia and Public Policy Chairman of the Association of Junior Leagues. The Association of Junior Leagues is an international women's volunteer organization with 243 member Leagues in the United States, representing approximately 148,000 individual members. Junior Leagues promote the solution of community problems through voluntary citizen involvement, and train their members to be effective voluntary participants in their communities. The Association's commitment to the improvement of services for children and families is long-standing. Junior League volunteers have been providing such services since the first Junior League was founded in New York City in 1901. In the 1970's, the Association and individual Junior Leagues expanded their activities on behalf of children and families to advocate for legislation and administrative changes directed at improving the systems and institutions which provide services to children and their families.

I appreciate this opportunity to appear before you today to express the Association's concern about the Administration's spending proposals for programs that are under the jurisdiction of the Finance Committee. We believe that these proposals would adversely affect some of our nation's neediest children and families. Twice in the past two years, representatives of the Association have appeared before this committee to urge you to preserve the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) and to support adequate funding for the Title XX SSBG. Fortunately for our nation's children and families, Congress, with strong support from this committee, responded positively to the pleas of child advocates to save P.L. 96-272, refusing to place it in a Social Services Block Grant as requested by President Reagan and, last year, refusing to make the second round of cuts in the SSBG requested by President Reagan.

### TITLE XX SOCIAL SERVICES BLOCK GRANT

The Association opposes further reductions in the Title XX Social Services Block Grant. As this committee is well aware, this program is the basic funding source for a variety of crucial social services provided in all of our communities. To highlight a few:

Child care services enable low-income parents to work or train for employment; the SSBG is the major funding source for child care for these parents.

Child protective services are increasingly necessary as reports of child abuse and neglect increase; the SSBG is the major federal funding source for these services.

Child welfare services such as those to children and families in foster care also are funded by the SSBG.

Home care services are essential for elderly and disabled persons to remain in their homes and avoid costly institutions; the SSBG remains an important source of funds for these services.

Title XX was severely cut by the Omnibus Budget Reconciliation Act of 1981, which reduced its funding level for Fiscal Year 1984 from approximately $3.3 billion to $2.5 billion. The great majority of states and localities are fully using all available SSBG funds at present—any further cuts in this program will be at the expense of the poorest of the poor. Recognizing the need for increased assistance under this program, Congress provided an additional $225 million for it as part of the Emergency Jobs Program (P.L. 98-8) passed by Congress and approved by the President on March 24, 1983. Now, the Administration is attempting to undo that action by proposing a reduced funding level for FY 1984. In addition, the Administration is requesting the repeal of the Community Services Block Grant which is currently funded at $343 million, suggesting that SSBG funds can be used for activities authorized under the Community Services Block Grant. This proposed change would further erode the capacity of social service administrators to meet the demands for social services. Programs funded under the SSBG and CSBG would be pitted against one another and would be competing for already insufficient resources. We urge this committee to resist these attempts to undercut programs that help poor women, children and the elderly.

Moreover, we urge the committee to increase the funding level for the Title XX Social Services Block Grant to $2.8 billion for FY 1984. Such a move would be in line with the Emergency Jobs Program originally approved by the Senate which included an additional $300 million for the SSBG (the $225 million in the jobs bill legislation was set in conference). If no increase in funding is voted for FY 1984, the increases provided under the emergency jobs legislation will have only been in effect for a short period and will doubtless result in termination of some service benefits before they have had the chance to be effective. We need to increase—not decrease—the funding levels provided by the jobs bill.

## HELPING COMMUNITIES MEET BASIC NEEDS

We base our recommendations to this committee on the reports from Junior Leagues across the country regarding the needs of their communities and their requests for assistance in meeting these needs. Led by the Junior League of Columbus, Ohio, Junior Leagues from all sections of the country co-sponsored the following resolution at the Association's Annual Conference held May 15-18 in Dallas, Texas:

"Be it resolved that the delegates return to their home communities more conscious of the need to continue to make our Junior Leagues better able to respond appropriately and expeditiously to the basic human needs of food, clothing, shelter, and utilities.

"Be it further resolved that the Association Board do all that is within its capabilities to enable the member Leagues to effectively assume such a vital and critical role."

The resolution was passed unanimously. In support of their resolution, the members of the Junior League of Columbus said:

"Many, many of us will return home this week to cities where 10 to 15 percent of the people live below the poverty level and a similar percentage are unemployed, many for the first time, constituting a population we now call the new poor."

The Columbus Junior League took this initiative because of the dramatic impact of these problems in their community. The community was able to partially respond to these needs because of the funds for emergency food and shelter included in the Emergency Jobs Program (P.L. 98-8).

## REPORTS FROM JUNIOR LEAGUE CHILD WATCH PROJECTS

Other unmet needs also are being discovered by many of the Junior Leagues participating in Child Watch, a citizens monitoring project developed by the Children's Defense Fund in collaboration with the Association of Junior Leagues. The Child Watch project of the Junior League of Wichita, Kansas, reports that:

Parents in need of inexpensive child care are opting for a number of solutions, some of them being highly undesirable.

Parents will accept any choice to remain employed—no supervision, relative/neighbor care, "look in" care by a neighbor.

In one case, an eight year old child looks after her three year old sibling.

One young mother left her two young children, age three and four, in the car in the parking lot of a plant where she worked.

As a result of the 1981 budget cuts, the number of day care slots funded by Title XX in Wichita, was reduced from 800 to 300 with AFDC recipients required to use the child care disregard to pay for their child care. This meant a number of children were shifted from child care settings with which they were familiar to new, often unlicensed, settings. Kansas also discontinued providing child care for mothers in training programs and reduced the eligibility for Title XX day care from 80 percent to 70 percent of the state's median income. In addition, the fees required of parents were increased by 25 percent.

Morever, from 1980 to 1983, the child care staff in the Kansas Department of Social and Rehabilitative Services (SRS) has been cut from nine to two persons. The United Way has increased allocations targeted to the local child care association. However, as a result of high area unemployment, United Way contributions are expected to result in a 3.5 percent shortfall in the projected allocation. Additionally, there has been an increase in the number of family day care providers whose own impoverished circumstances make them personally eligible for the federal commodities (e.g., food) programs.

In my own home state, the Pittsburgh Junior League's Child Watch interviewers report that many believe an increase in the ratio of adult staff to children in child care has resulted in a reduction in the quality of care. The Pittsburgh Child Watch project also reports that transportation subsidies have been severely cut back, eliminating transportation services for children with emotional disabilities. Additionally, preventive services aimed at pre-school children have been lost, a factor which may result in the need to spend more money in the future as the children grow up and their problems worsen. Service providers are also projecting that one in ten families are experiencing some type of sexual abuse problem yet funds are insufficient to provide the special services these children and their families need.

In Pittsburgh, the reduction in Title XX funds for homemakers also is seriously restricting the provision of services to children who have been deinstitutionalized and returned home in keeping with a mandate to reduce institutional services in favor of more effective and less costly home-based services for children at risk.

In Birmingham, Alabama, the Child Watch project reports that high unemployment coincided with a reduction in available day care slots. For many families interested in returning to work, the lack of sufficient quality child care is a major impediment in enabling a return to gainful employment.

Both the Birmingham Child Watch project and the Pittsburgh Child Watch project also report problems resulting from the impact of Title XX cuts on homemaker services. In Birmingham, the majority of the population seeking homemaker services had traditionally required short-term assistance when a family member was hospitalized. Over the last several years, however, the population seeking services has changed dramatically. Now, the overwhelming majority is seeking assistance because of abuse and neglect. This population requires more skilled homemaker services. However, the cuts in Title XX funds make it impossible to provide the type of skilled homemaker services required.

### REPORTS FROM OTHER JUNIOR LEAGUES

In Onondaga County, New York, the Director of the Onondaga Child Care Council, an organization whose board includes a representative of the Junior League of Syracuse, reports that the demand for child care among single mothers is increasing as a result of a slight upturn in employment. However, because the eligibility levels for Title XX child care have been lowered, most women are ineligible for child care assistance despite the fact that their jobs are primarily entry level positions paying low or minimum wages. In the New York State Child Care Coordinating Council's study, "Where Have All the Children Gone," it was reported that one mother has refused pay raises and promotions in order to maintain her child's eligibility for day care.

Similar problems exist in Philadelphia where I represent the Junior League of Philadelphia on the Day Care Advisory Committee for Philadelphia County. Because of a sharp drop in Title XX funding (from $24.7 million in 1979-80 to $16.4 million in 1981-82), the county eliminated its child care program for latch key children as well as its recreation and camping program—another program designed for school-age children. In addition, child care providers report that many parents are unable to pay their share of the child care costs required by the sliding fee scale established after the 1981 cuts in Title XX. As a result, the agencies are being forced to drop from their roles children with no other child care available to them.

### ADOPTION ASSISTANCE AND CHILD WELFARE ACT OF 1980

Over the past two years, the Administration has sought to restructure the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96–272) by placing it in a block grant with reduced funds. The Association worked extensively for the passage of P.L. 96–272 and vigorously opposed any attempts to alter it. We continue to believe that the best interests of children would not be surved by giving up the structure created by this law, which was passed in 1980 with strong bipartisan support after almost five years of effort by child advocates. Fortunately, Congress has refussed to dismantle P.L. 96–272 or to allow any change in its carefully-crafted structure which was designed to reform this country's child welfare system. This landmark legislation provides fiscal incentives for states to redirect their child welfare services from the provision of out-of-home care to the development of preventive and reunification services. When reunification of families is not possible, the procedural reforms mandated by Public Law 96–272 encourage th etermination of parental ties and moving the child out of foster care into a permanent adoptive home. Public Law 96–272 mandates procedural reforms such as the development of case plans, case reviews, including a dispositional hearing after a child is in care 18 months, and inventories of children in foster care, and establishes a subsidized adoption program for children with special needs—mental, physical or emotional handicaps.

The Administration's proposals under consideration by this committee retain Public Law 96–272 as a separate piece of legislation, but would seriously alter its intent by placing a cap on foster care without providing any additional funds for preventive and reunification services. Public Law 96–272 stipulates that a cap may not be placed on foster care unless $266 million is appropriated for Title IV–B of the Social Security Act (child welfare services) in fiscal year 1984. Title IV–B is currently funded at $156 million. The Administration proposes to lower this funding level further by abolishing the separate authority for child welfare training grants and requesting $156 milion for fiscal year 1984 for child welfre services and child welfare training combined. This would mean another funding cut of four million dollars for child welfare services.

We urge the committee to reject the Administration's proposals and maintain Public Law 96–272 as passed by Congress in 1980. To cap foster care without providing additional funding for preventive and reunification services might endanger the lives of many children. In fact, in some communities, the crisis in basic needs has led to an increasing number of child abuse cases resulting in a need for foster care. For example, the Child Watch project of the Junior League of Hartford, Connecticut, reports increased incidences of children being denied basic needs such as food, and states: "The number and severity of child abuse cases are increasing, resulting in the placement of more children in foster care." Other projects have reported parents resorting to foster care for their children because they were unable to provide adequate food and shelter for them. This trend also appeared in a survey of its 200 affiliates conducted by the Council of Jewish Federations.

We also object to the elimination of child welfare training funds. The separate authority for child welfare training grants as part of Title IV–B is a very important component with the Association believes results in a better trained service delivery staff. If the separate child welfare training grants are discontinued, quite likely training will become less of a priority and services will suffer.

Both the Pittsburgh and Wichita Child Watch projects found that funds for child welfare training of staff and foster parents have been cut back. In Wichita, there is a new requirement that all foster parents receive a minimum of six hours of training annually, yet the Department of Social and Rehabilitative Services (SRS) training budget for fiscal year 1983–84 has been cut in half. Surely, this is not the time to eliminate funds for child welfare training.

### SUPPORT FOR ADOPTION ASSISTANCE

However, the Association does applaud the Administration's decision to retain the adoption assistance provisions of the new Title IV–E of the Social Security Act and supports the Office of Human Development Services' (OHDS) special initiative to move children with special needs out of foster care and into adoptive homes. The goal of Assistant Secretary Dorcas Hardy of OHDS to double the number of children placed in permanent homes using subsidized adoptions is a laudable one. However, such an incentive will only be successful if states are certain that Public Law 96-272 is secure. Although all 50 states and Washington, D.C. have come under Title IV-E as required by Public Law 96-272, only 29 states had requested funding on the adoption assistance as of March 31, 1983. Many states were wary of launching a program unless there is an assurance funding will be forthcoming.

In addition, while the Administration appears to have dropped its plans to turn Public Law 96-272 into a block grant for the moment, it is important to note that S. 763, the State Fiscal Assistance Block Grant Act, which was introduced in the Senate on March 10, 1983 by Senator Orrin Hatch (R-UT) at the request of the Administration, includes both Title IV-B (child welfare services) and Title IV-E (foster care and adoption assistance programs). Such a stance is hardly conducive to building confidence among state administrative responsible for intiating the new programs mandated by Public Law 96-272. We wish to reaffirm our opposition to this proposal because we believe it is essential to the welfare of children that the structure of Public Law 96-272 be preserved intact so that states will be encouraged to move ahead with the long-overdue reforms it mandates.

In conclusion, we urge the Finance Committee to continue its leadership in protecting social services programs for children and their families by maintaining Public Law 96-272 and raising the funding level for the Title XX Social Services program.

Once again, I thank you for allowing me to appear before you today on behalf of the Association of Junior Leagues.

The CHAIRMAN. Senator Danforth?

Senator DANFORTH. No questions, Mr. Chairman.

The CHAIRMAN. Senator Chafee?

Senator CHAFEE. I have no questions, Mr. Chairman.

The CHAIRMAN. Senator Pryor?

Senator PRYOR. I have no questions.

The CHAIRMAN. I may have a question or two. First, I want to thank the witnesses. We appreciate very much your testimony. As we have indicated in the past we share the concerns you have expressed this morning. We have worked closely with each of your groups in the past and will continue to do so in the future. Even though there are great budget pressures, there are great problems, too. I think it is a question of priorities of which we hope we can properly address.

Miss Russell, have you had a chance to visit with anybody at the Department of Health and Human Services or in the White House about your program?

Miss RUSSELL. I think we are going to try this afternoon. I saw Mrs. Reagan yesterday.

Senator PRYOR. That is a pretty good start. [Laughter.]

The CHAIRMAN. The only reason I make that point is because you have stressed the private sector. And it seems to me that there is some support in the White House for stressing the private sector. We also understand the responsibility which rests with the Federal and State programs.

Miss RUSSELL. We saw Vice President Bush last year, and we are supposed to see Secretary Heckler today if possible.

The CHAIRMAN. If you see her, tell her hello for us.

Miss RUSSELL. If she is back from Denver. [Laughter.]

The CHAIRMAN. Well, we will be working with all of your organizations. I don't have any further questions. We understand the real need. We understand that the States are out of money, but they don't have near the problem the Federal Government has. Most of them are cash basis law States. So they don't have the debt that we have. We had to increase the debt ceiling 2 weeks ago to $1.4 trillion. We are told that we have got budget deficits in excess of $200 billion a year coming up for 3 straight years. But even so, that does not mean that we don't have important obligations. And there are many of us—I hope a majority—who are willing to reestablish priorities, both on the revenue side and on the spending side.

Senator Danforth?

Senator DANFORTH. Mr. Chairman, I have no questions to ask. But I would like to make a point. We have here a list of recommendations from the administration, oh, 20 or so recommendations, for specific adjustments in programs, which amounts to a grand total of about $2 billion over a 3-year period of time. Now, the budget problem over a 3-year period of time is not any $2 billion, but rather it is about $200 billion for each of those 3 years.

We are fooling ourselves if we think that we can fix the budget with this nickel and dime stuff. We went through a period of budget cuts in 1981, 1982, largely aimed at programs that help the poor and the needy—the appropriated programs—and my guess is that if we were to compute all of the savings of all of the budget cuts in 1981 and 1982, we would not make up for the increase in the Federal budget in simply servicing the national debt. And, therefore, it seems to me that the time has come for some realism in dealing with the budget. And the realism is that the money is not there in this nickel and dime stuff. And what we are going to have to do is take a much bolder approach, and the bolder approach has to be aimed not at things that help poor people or disadvantaged people but in the kinds of things that really affect Mr. and Mrs. Average American.

Senator Boren and I proposed a couple of weeks ago a 4-year proposal for adjusting indexing formulas for both entitlements and for taxes when they become indexed in 1985. That would raise about $117 billion over 4 years. It is still a long way, I might say, from solving the problem. But it seems to me that the longer we go in thinking that there is some easy answer or that there is some nickel and dime answer to a major budget problem, the longer we are putting off the inevitable facing of reality. And, therefore, my hope is that both the administration and the Congress could shift our sights away from this kind of an approach, and that we could look at the broader—and, granted, politically impossible; maybe politically intolerable—things that really have to be done to reduce this deficit to manageable proportions.

My contention, Mr. Chairman, is that we could come up with any list of spending cuts, such as these, any list of what to do about the Defense budget, the most favorable economic assumptions around and still it would be impossible to reduce the size of the Federal budget in any year from now on to less than $150 billion unless we are willing to come together with a bipartisan approach which would both increase revenues beyond what is provided in present law, and which would provide for some containment in the entitlement programs which are so popular, and at least heretofore untouchable.

So I just wanted to make this point. I honestly think, in looking over the administration's proposals, that they might be worth considering, and some of them might be worth doing. But they are not going to accomplish a foot on the path to getting the deficit under control. It is almost a useless package in my view.

The CHAIRMAN. I thank the Senator from Missouri. There is the famous admonition of the late Senator Dirksen, however, that a billion here and a billion there soon adds up to real money. That is sort of where we are. Maybe we can't do it a billion at a time. I am not going to pass judgment on any recommendation of the administration; obviously, some will be rejected out of hand.

Senator DANFORTH. I would like to add that I honestly believe that that well-known admonition of Senator Dirksen is simply outmoded.

The CHAIRMAN. It probably should be a trillion now.

Senator DANFORTH. A trillion.

The CHAIRMAN. A trillion here and a trillion there soon add up to real money.

Well, we appreciate very much your testimony. And we will probably be in touch with you later on. We may never have a budget resolution. It is the biggest floating game in town. They meet every day and nothing has been accomplished. But if and when there ever is a budget resolution then it is our responsibility to respond to its requirements. In many areas—and certainly this is one very important area—I would just indicate that we believe we understand the priorities. We believe you understand the priorities, as do we. And in most areas there is almost complete agreement.

Senator PRYOR. Mr. Chairman, at this point, because one or two of the witnesses have mentioned title XX, I think it might be good if the staff, if we have not already done this, it might be in keeping with something that Senator Danforth has mentioned at this point in the record to have a breakdown of the 50 States usage of the title XX funding. In the past, I think it has been true—it may not be present today—that some of the States have not, in fact, utilized the funds that have been sent to the States under the title XX program. Now I don't know whether that is true. I know one personal experience back years ago when I was a Governor, I know a year or two we didn't use all of our funding. And the reason we didn't is we didn't want to waste it. And I just think it might—and I am not saying that they were not—I think some of the programs were not ready to be funded. And so I think there was a year or two that we did not utilize funding. I think it might be good to have an update is what I am saying on title XX maybe.

Miss CRAWFORD. If I could comment on that.

Senator PRYOR. Certainly.

Miss CRAWFORD. I believe that is the 1981 figures, which is the latest available, that 99 percent of funds were used by the States.

Senator PRYOR. All of the title XX funding. Well, I think that might be a good taste——

Miss CRAWFORD. We could not get any later figures. They were not available.

Senator PRYOR. Possibly the National Governors Conference or our staff from the committee might want to insert a table on this.

Miss CRAWFORD. That would be very helpful.

Senator PRYOR. Thank you.

The **Chairman**. We will try to obtain that information. We want to thank you very much.

Our next witness panel consists of Leon Ginsberg, commissioner of West Virginia Department of Welfare, and MaryLee Allen, director of child welfare and mental health, children's defense fund.

Dr. Ginsberg, do you want to proceed?

Mr. **Racine**. Let me make a clarification.

The **Chairman**. Oh, you are not Dr. Ginsberg?

Mr. **Racine**. No.

The **Chairman**. I didn't think you were Dr. Ginsberg.

Mr. **Racine**. Dr. Ginsberg's train has been delayed.

The **Chairman**. What is he on, Amtrak?

Mr. **Racine**. Possibly. I think it goes to show you what happens when you try to save money. [Laughter.]

He will be shortly, I hope. What we would like to do is have the children's defense fund testify first.

The **Chairman**. Well, if he doesn't arrive, his statement will look very good in the record. Yes, Miss Allen.

## STATEMENT OF MS. MARY LEE ALLEN, DIRECTOR OF CHILD WELFARE AND MENTAL HEALTH, CHILDREN'S DEFENSE FUND, WASHINGTON, D.C.

Ms. **Allen**. Senator Dole and members of the committee, I am Mary Lee Allen, director of child welfare and mental health at the children's defense fund. CDF appreciates the opportunity to testify this morning as you consider the administration's proposed spending reductions for fiscal year 1984. As you well know, the children's defense fund has been extremely concerned that poor, sick, handicapped, and abused children and their families have borne the brunt of the budget decisions of the past 2 years. We are further troubled by the administration's proposals for additional cuts for fiscal year 1984 in key programs affecting many of these same children and families. We are pleased that in its budget deliberations this year, both the House and Senate have rejected the administration's budget proposals, for the most part, and we, like you all, are anxiously awaiting the outcome of the budget conference.

We urge this committee, too, which last year did reject some of the proposed cuts, to reject the administration's proposals for changes in AFDC and medicaid, the maternal and child health and social services block grants, and the child welfare and foster care programs.

Many of these proposals were considered by the Congress last year and were rejected or made optional for the States.

You have already heard and will hear more in these next 2 days about the harms imposed on children and families by the recent budget cuts. In short, medicaid and child welfare and other social services have been severely weakened just as more families losing jobs or AFDC have needed their support. Clinics and hospitals have seen their revenues shrink but their caseloads increase. Child welfare agencies have faced reductions in staff, and had to impose fees on services, while at the same time reports of abuse and neglect, and in some States numbers of children in foster care have increased. Families who had been receiving modest AFDC payments and continuing to work to support their families have in some States been left without access to health care or to child care.

Under the leadership of this committee, some inroads have already been made on these problems. In the health area, you have required medically needy programs under medicaid to include maternity services for pregnant women and ambulatory care for children. Last year, you exempted poor pregnant women and children from medicaid copayments. Your commitment to the Adoption Assistance and Child Welfare Act of 1980 has also kept intact an important preventive framework.

Today, although we do recognize the pressures upon you, we ask you to consider going a step further and to take three specific actions. First, we ask that you act to restore the work incentives in the AFDC program. We believe that the families, including over 700,000 children, who have been cut from AFDC as a result of changes in the work disregards, are continuing to struggle to work and survive without it. However, in some instances, they are doing so at a tremendous price. We worry about the long-term cost to families if their children's health problems go unattended, or if the daily pressures of living result in abusive behavior.

Second, we have three recommendations in the health area: First, reforms in medicaid to provide coverage to children and/or pregnant women solely on the basis of whether or not they are poor; second, automatic medicaid eligibility for newborn babies; and third, an increase in the authorization ceiling for the maternal and child health block grant from $373 million to $478 million. It is the level at which the block grant is funded under the emergency jobs bill.

These changes will address the worse inequities in Medicaid eligibility policies which cause millions of poor children, pregnant women and newborns to forego the benefits of cost effective preventive health care. The increase in the MCH authorization will enable the 47 States that have reduced services or restricted eligibility to begin to make needed restorations.

As a third step, we urge you, too, to increase the authorization for the Social Services Block Grant from $2.5 billion to $2.8 billion for fiscal year 1984. This increase will help States address the overwhelming demand being made on protective service agencies around the country. It will also allow agencies to better meet the child care needs of working families. Toward this same goal we echo the recommendations you have already heard this morning for your continuing support in maintaining the Title IV–E Foster Care and Adoption Assistance Programs, and ask for your help in securing increased funding for the Title IV–B Child Welfare Services Program.

We believe that the restorations in these three areas will go a long way toward beginning to repair the holes in the safety net for children. Children look to this committee for leadership on their behalf. Thank you.

Senator DANFORTH. Thank you, Miss Allen. Dr. Ginsberg?

[The prepared written statement of Miss Allen follows:]

## TESTIMONY OF THE CHILDREN'S DEFENSE FUND; PRESENTED BY MARYLEE ALLEN, DIRECTOR, CHILD WELFARE AND MENTAL HEALTH, CHILDREN'S DEFENSE FUND

Mr. Chairman and Members of the Committee, the Children's Defense Fund (CDF) greatly appreciates the opportunity to appear before you today as you continue your serious consideration of the Administration's proposed spending reductions for fiscal year 1984.

The Children's Defense Fund (CDF) is a national public charity created in 1973 to provide a systematic voice to improve the lives of children and place their needs higher on our nation's public policy agenda. CDF has issued a number of reports on major problems facing large numbers of children in the areas of child welfare, child health, child mental health, child care, and education. In each instance, we have not only documented the problems, but have sought to develop a careful and responsible agenda for reform that would help redirect public policies and public funds in a more effective fashion.

Earlier this year CDF prepared a report on the impact of the $9 billion in cuts from federal programs for poor children and families that occurred in fiscal year 1982 and fiscal year 1983, and the anticipated impact of the additional $3.5 billion in cuts proposed by the Administration for fiscal year 1984. I would like to submit that report, A Children's Defense Budget, for your review today.

For the past two years, CDF, in collaboration with the Association of Junior Leagues, has also been monitoring the impact of federal budget cuts on our neediest children and families through Child Watch. Child Watch projects, involving nearly 1000 volunteers, are underway now in over 100 communities in 39 states.

The results of these various monitoring efforts bring us before you today to oppose further cuts in several major federal programs affecting poor children—AFDC, Medicaid, the Social Services Block Grant, and the Child Welfare and Foster Care Programs.

CDF recognizes the extremely difficult task faced by Congress and this Committee specifically, in attempting to shape the federal budget not only for the 1984 fiscal year, but for future years as well. We all acknowledge the severe limits of federal resources, and the fierce competition for already scarce dollars. But we must also acknowledge that critical choices can and must be made this year, choices immediately affecting the lives of millions, and affecting the future health, economy and security of our very nation.

The consequences of your budget and programmatic choices are enormous and cannot be underestimated. A review of the impact of recent budget actions highlights the importance of thoughtful and sound decisionmaking by the Congress in this year's budget debate.

The budget policies of this Administration and the 97th Congress have created pain and suffering for millions of Americans. Children—the promise of our future—have been especially hurt as more than $9 billion has been cut from programs supporting them and their low income parents. The results are devastating:

2.5 million more children live in poverty today than two years ago.

1.5 million children have lost at least some of the critical support provided through the AFDC program. Most of these children have also lost Medicaid.

All 50 states have reduced their Medicaid program for mothers and children.

Over 200,000 children and mothers have lost preventive Maternal and Child Health Services.

One million people, many of them children, have had their Food Stamps eliminated and about 4 million have had their benefits reduced.

1.1 million low income children have lost free and reduced-price lunches.

One third of Americans are children, and yet more children now live in poverty than any other age group in this country, and the poverty rate for children is climbing. The incidence and severity of child abuse is found to be on the rise and in some urban areas of the country the infant mortality rate has also begun to rise for the first time in decades.

The harmful effects of a budget strategy that hurts children must cease. we are pleased therefore that both Houses of Congress have rejected most of the budget cuts proposed by the Administration for fiscal year 1984. We urge this Committee too to forcefully reject the Administration's cuts in AFDC, Medicaid, and the Social Services Block Grant, and to send a strong message to this Administration that the 98th Congress has charted a new course, a course that protects its most vital resources and invests in its human capital—children.

As you embark upon this new course, we urge you to make modest changes in the AFDC, Medicaid, Maternal and Child Health and Social Services programs that we believe will go a long way toward beginning to repair the holes in the safety net caused by the unfair budget policies of the last two years.

Our specific proposals for each of these programs, as well as our justifications for the need for such changes, are discussed in more detail below.

### AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

The almost eight million children dependent upon the AFDC Program for survival, over half of whom are under eight years old, are desperately needy and have already been severely hurt by the AFDC program's failure to keep up with inflation.

AFDC recipients get no automatic cost of living increases and state AFDC payments have generally not kept pace with inflation. In fact, the Congressional Budget Office, in the AFDC cost projections it gives this Committee, assumes that only one half of the impact of inflation is covered by states.

AFDC benefits in 33 states increased less than 40 percent between 1975 and 1981. Although 29 states increased the maximum grant for three-person families between January 1981 and January 1983, there were only seven states where the increase equalled the increase in the consumer price index of 12.5 percent. Further as of January 1983, in 36 states even the combined AFDC and food stamp benefit level for a family of three was less than 75 percent of the 1983 poverty level. The combined level exceeded 90 percent of the poverty level in only four states. A mother with two children still receives only $96 per month in AFDC in Mississippi, and only $117 and $127 per month in Texas and Tennessee respectively.

Many of these truly needy children and their families have been severely hurt by the budget cuts and program changes of the past two years.

First, the Omnibus Budget Reconciliation Act of 1981 (OBRA) slashed the $7 billion federal AFDC program by slightly over $1 billion for fiscal year 1982. Combined with a resulting loss in state matching funds, this constutes a total AFDC cut of almost $2 billion. Then the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) cut federal expenditures for AFDC by an additional $85 million for fiscal year 1983. Each of these deep cuts in funding carried with it fundamental and permanent changes in the underlying AFDC statute. The Congressional Budget Office estimates that OBRA and TEFRA reduced federal funding for AFDC and Child Support Enforcement by $6.10 billion for fiscal year 1982 through fiscal year 1986, which means reductions in total benefits of as much as twice that amount.

The impact of the AFDC cuts on poor working mothers and their children was staggering. Nationally, state welfare officials estimated that 725,000 families, including 1,450,000 children, lost AFDC eligibility or had their grants reduced due to fiscal year 1982 changes in federal law alone. And the effects of the fiscal year 1983 cuts have yet to be fully assessed. Although the greatest impact was on working families, a study by the Center for the Study of Social Policy indicates that even AFDC recipients with no earnings, the "truly needy," lost an average of $27 per month nationwide as a result of the OBRA and TEFRA changes.

Very simply, families who lost AFDC or whose benefits were reduced because of the new restrictions on earned income cannot make ends meet. They are going without basic necessities:

In New Jersey, a survey of recipients who lost AFDC found that nearly 40 percent of the families had times when they did not have enough to eat; 20 percent could not afford warm clothes for their children in the winter; 40 percent had parents with medical problems they could not get treatment for.

In Maryland, a state survey found that 68 percent of terminated recipients had trouble paying for food and medical care. Over 45 percent had trouble paying for rent, heat, and utilities, and 39 percent had to take food or money from friends and relatives to survive. Thirty-one percent had to change their child care arrangements.

In twenty two states, loss of AFDC meant loss of Medicaid benefits as well. Even in the other states which offer "medically needy" programs for families outside of the AFDC program, the benefits available are often more restrictive than those available for a family receiving AFDC. In Tennessee, for example, the state will pay for visits to a doctor by a sick child who receives AFDC, but generally will not pay for such visits if the child is enrolled in the "medically needy" program. Private health insurance plans offered by employers will not pick up the slack for the vast majority of working families who lose AFDC. Only 27.4 percent of families reporting AFDC or other public assistance income also reported coverage of any household members by group health insurance. And even this often means that the worker is covered but his family is not.

Consider the impact of the AFDC cuts on just one mother:

One Maine mother continued to work after losing her AFDC supplement of $180 a month. But she could make ends meet only by cutting out essentials. From a take-home pay of $376 a month, she had to pay $120 a month in day care costs and $200 a month for shelter. She received $75 in food stamps, which supplied food for herself and her child for two weeks.

She stated:

"By use of simple arithmetic, I figure I have a whopping $56 a month to buy food for the rest of the month as well as to cover [clothing, laundry, transportation, and medical costs]. I am badly in need of dental work, my daughter needs new shoes, but there is no money left for these things. And I know of women who are in situations worse than mine—who have more children than I do, who pay more rent, who are not able to stretch their food stamps and pennies as far as I can, whose children have their only real meal at noon at the day care center or the babysitter's."

Considerable attention has been given in the last several months to recent research findings that families cut from AFDC as a result of OBRA's work-related changes did not return to the AFDC rolls within one year. However, we believe, in view of unmet needs like those described above, that such attention has been misdirected.

Too little attention has been directed toward the consequences for the well-being of families who have been cut from AFDC. How have they been able to survive? At what price are these mothers continuing at their often minimum wage jobs? What will be the long term costs to these families if their children's health problems go unattended, or the stress of daily living culminates in abusive behavior? The data above gives us a sense of how rough it is. And the recent study by the Research Triangle Institute itself documented that many of the families studied are struggling without health insurance of any kind and are often dependent upon relatives and neighbors for child care.

Similarly, the costs for these families to stay off of AFDC, not only in human terms, but in terms of expenditures for state and local social welfare programs, also needs further attention. Preliminary reports, for example, indicate that increases in General Assistance Programs in Pennsylvania and New York could be attributed to transfers from the AFDC Program.

Certainly if offsets against emergency food pantries and other social services were possible, the total costs would be significant. Reports from our Child Watch Project paint a dismal picture of families exhausting their resources and turning in despair to community agencies. Increases in requests for cash assistance, food, clothing, and utilities was a consistent theme throughout the Child Watch projects.

Despite such findings, the Administration is now proposing to cut the AFDC program another $732 million for FY 1984, or an additional $2.5 billion through FY 1986.

With one exception the Administration's FY 1984 AFDC proposals are those that were considered by the Congress last year and rejected as too punitive or harmful to children and families, or were made optional for the states. Many of the AFDC changes proposed for FY 1984 strike at the poorest of the poor, those relying solely on their AFDC grant for subsistence.

One of the major proposals, for example, would penalize families who are sharing housing with others in order to conserve limited resources and survive on their already inadequate AFDC grants. The proposal would require that reduced benefits be paid whenever there is a person living in a household with the AFDC unit, whether or not that person has any income of his or her own and is contributing it to the unit. While TEFRA allowed states to prorate the allowance for shelter and utilities, no state has, as yet, opted for such a provision.

Data show that AFDC families typically share housing with other individuals who either do not have income or whose income is so limited that they, too, are forced to share housing to survive. According to the latest published HHS data, 1.4 million AFDC families share living quarters with people not included in their AFDC grant. Almost half of these families share living quarters with children who are included in the grant (for example, disabled children receiving Supplementary Security Income or children still in school but too old to receive AFDC); 28 percent share housing with adults who are themselves dependent on public assistance. Yet the Administration estimates federal savings in fiscal year 1984 alone of $229 million, an assumed benefit reduction to these poor families of over $400 million.

Benefit reductions that will result from this and the other changes proposed for fiscal year 1984 will continue to jeopardize thousands of poor children. Therefore, we urge this Committee to act now to reject any further cuts in the AFDC Program which addresses the most basic survival needs of our most vulnerable citizens.

We ask too that you not turn your back on the over 725,000 poor working families who lost their AFDC eligibility or had their grants reduced as a result of the fiscal year 1982 changes in the program. We urge you to consider now modest restorations to the AFDC Program which will begin to address several of the harms imposed by the hastily imposed and ill-conceived cuts in 1981. These are provisions similar to those approved by the House Ways and Means Committee in August of last year as part of H.R. 6878. Although by no means sufficient, they are a beginning. The specific restorations include:

1. *Eliminating the cap on AFDC eligibility set at 150 percent of the state need standard.*

OBRA limited AFDC eligibility to families whose gross income, less child care and other work-related expenses, up to a maximum, did not exceed 150 percent of their state's standard of need. The 150 percent limit cut many poor working families off AFDC entirely. As of February 1982, every state's standard of need, and in 37 states 150 percent of the standard of need, fell below federal poverty guidelines. In over 30 states 150 percent of the standard of need was less than the monthly minimum wage for a 40 hour week. For example, a family of four in West Virginia with countable income of $498 per month (64 percent of federal poverty guidelines) would lose even a partial AFDC grant because of the 150 percent cap. In Texas, a family of three with an annual income of $3,025 would be ineligible for AFDC. Yet in Texas, loss of AFDC also means automatic loss of medical assistance. Although some states did raise their need standards in order to allow working recipients to be eligible for AFDC, many more did not.

2. *Restoring the work incentive disregards by eliminating the four month limitation on the $30 and ⅓ disregard and changing the order for applying the disregards.*

State welfare administrators projected that the OBRA changes in the work incentive disregards accounted for 26 percent of all AFDC cases closed due to OBRA changes and for 46 percent of all cases whose benefits were reduced. Eliminating the $30 and ⅓ disregards after four months discourages recipients from working. In fact, parents with high work-related expenses and child care costs are in some states worse off than if they were not working at all. Some states, Wisconsin and Utah for example, have reported that their AFDC costs have increased due to the loss of the disregard after four months. Data from Wisconsin show that over 50 percent of the cases terminated due to the loss of the $30 and ⅓ disregard are back on AFDC within two and one-half to three and one-half months, and many of them have reduced earnings and consequently are receiving larger grants.

3. *Raising the maximum amount of allowable work expense deductions.*

We also support increasing from $75 per month to 20 percent of gross earnings (up to a maximum of $175 per month) the amount of work-related expenses that can be subtracted from earned income in calulating a family's AFDC eligibility and benefit levels. The arbitrary limit imposed on the work expense deduction in 1981 is inadequate. The $75 maximum is participarly inadequate if it is interpreted, as it has been by some courts, to include mandatory payroll deductions such as Social Security and federal taxes, as well as transportation, uniforms and small tools. In Maryland, for example, a mother with two children working full time at the minimum wage will have mandatory payroll deducations of $84.60 per month for federal, state and local taxes and FICA. Given the confusion surrounding application of the $75 work expense deduction, it is essential that Congress clarify the issue by providing a work expense deduction that reflects the real costs of working.

Inclusion of these minimal restorations in the AFDC Program will restore work incentives to many single women struggling to support their families and also represent a cost-effective investment in our nations most vulnerable children.

## HEALTH CARE FOR MOTHERS AND CHILDREN

In the last decade enormous gains have been made in the health status of this country's children. Publicly financed health programs have played a major role in achieving these improvements. For example, in the decade before Medicaid, infant mortality rates changed very little. Following enactment of Medicaid, infant mortality rates fell sharply: from 25 deaths per 1,000 live births in 1965 to 13 deaths per 1,000 live births in 1979. Medical technology has been critical to this decline, and Medicaid coverage of prenatal care and delivery has made these benefits accessible to the poor.

A recent Urban Institute examination of infant mortality in America found a direct relationship between state Medicaid policies and birth outcome. The report concluded that states which do not cover first-time pregnancies under their Medicaid programs have higher neonatality rates than other states. The report furthermore reported that Medicaid coverage leads to earlier and more frequent prental care for mothers.

Despite a decade of advances and the proven impact of federal health programs, sharp disparities in the health of American mothers and children still exist. Income, race, and geographic location are still key factors in determining who gets access to health care. Millions of children and pregnant women suffer from poor health, have no place to go for health care, and no way to pay the doctor or hospital bills.

One in 89 infants in the United States dies each year. Minority infants and children, even in 1980, were three times as likely to have a mother who died in childbirth and twice as likely to die during the first year of life as nonminority children.

Over 35 percent of all preschool American children are not immunized against diptheria, tetanus, or pertussis. Almost 40 percent are not immunized against polio, and almost 50 percent are not immunized against mumps.

Over one in 20 pregnant women in the United States receives late prenatal care or none at all. About one in 11 Black pregnant women receives late or no prenatal care.

Medicaid reaches only about 40 percent of all impoverished persons in the United States. Eight million children living in poverty are not covered by Medicaid. Yet, low-income children suffer more illness and are more at risk of dying than other children. For example, a recent Maine study showed children from low-income families die at a rate nearly seven times greater than that of other children.

The relationship between insured status and use of health care is dramatic. Regardless of needs, the inability to pay for health care is a barrier to access. Insured persons receive 54 percent more physician care and 90 percent more hospital care than do the uninsured. In the poorest areas of the country, such as the South, insured persons receive three times as much hospital care as do their uninsured counterparts.

The unmet health care needs of mothers and children predate the Reagan Administration. However, this Administration's health and budget policies have undermined, cut, and repealed effective maternal and child health programs leaving hundreds of thousands more children and families in jeopardy. In 1982 human services officials from 55 cities nationwide ranked health care programs as the most common area affected by federal budget cuts. Cities received a 42 percent cut in health care funds. They provided health care to 10 percent fewer people in 1982 than in 1981. In addition, this Administration has failed to take affirmative action to strengthen the capacity of the public health care system to respond to the increasing numbers of needy Americans, many the victims of sustained high unemployment rates.

No more apparent is the health care gap than in the area of maternity care. It is widely accepted that access to early and continuous prenatal care is crucial to birth outcome. In an examination of infant mortality, the Urban Institute found that, next to birthweight, access to prenatal and delivery care is the greatest determinant of infant mortality.

Moreover maternity care is cost-effective. According to the National Center for Health Statistics, every dollar spent on prenatal care saves four dollars in avoided hospital and medical expenses. Care for newborns and young children is also highly cost-effective. A recent study conducted by the California Health Department found that by providing inexpensive and continuous followup to high-risk newborns, the state not only reduced infant mortality and the incidence of child abuse but also saved over a half million dollars in Medicaid expenditures.

Nevertheless, there are large numbers of pregnant women going without maternity care, and their numbers have increased in the last several years:

A September 1982 Oregon survey of 1,458 pregnant women on WIC found that 10.2 percent were receiving no prenatal care; 13.3 percent did not know or had not made plans for delivery; 9.3 percent were planning to show up at a hospital in labor; and 4.5 percent (66 women) reported they were having home deliveries because they had no money for hospital care.

A survey in two Kentucky counties found that nearly twice as many pregnant women in 1982 did not receive prenatal care as compared to any previous year.

Mothers who did not receive prenatal care were twice as likely to have their newborn babies referred to a neonatal intensive care unit (at a cost of $1,000 a day and a 23-day average length of stay) as mothers who did receive prenatal care.

A study of prenatal care over a ten year period conducted by the Oregon State Health Department found that the proportion of births to mothers who had inadequate prenatal care (no care or late care, or fewer than five visits) declined from 8.2 percent in 1972 to 6.0 percent in 1980. However, in the 18 month period after 1980, the percent of mothers with inadequate care increased by one-sixth to a total of 7.0 percent of all births. This represents about 2,800 infants. At least 400 of these will have no care at all. The proportion of births to 18 and 19 year-old mothers with inadequate care increased by half, from 11.0 percent to 16.3 percent for the first half of 1982. If the 1982 rate continues without any increases, 550 infants will be born in 1982 to 18 and 19 year-old mothers who did not get adequate prenatal care.

### THE IMPACT OF THE MEDICAID CUTBACKS

The cutbacks in the Medicaid program since 1981 have seriously exacerbated an already grim picture painted by unemployment and the loss of health insurance. The ticket to health care is the ability to pay for care, either out-of-pocket or through public or private health insurance coverage. Medicaid, the largest public insurance program for families with children, has been weakened just as more families losing their jobs or public assistance have needed its support.

An estimated 10.7 million people, including children and spouses, lacked health insurance coverage at the end of 1982 because of joblessness. Young workers, those most likely to have young children, are most likely to be unemployed.

For the newly impoverished and uninsured families, and for approximately 9 million of the poorest children in America, the Medicaid program is the only way to pay for checkups, medical treatment, dental care, hospitalization, and needed drugs. For hundreds of thousands of pregnant women, the program pays for prenatal care and delivery services. Children, more than any other age group, rely on Medicaid to pay their medical bills. In 1979, 55 percent of the public dollars paying for children's health care was spent through Medicaid. Medicaid accounted for only 28 percent of the public health funds spent on other age groups.

However, Congress passed $3.1 billion in Medicaid cuts in fiscal year 1982, fiscal year 1983, and fiscal year 1984 under the Omnibus Budget Reconciliation Act of 1981. In 1982 the Reagan Administration proposed cutting $8.6 billion more out of the program—a total of $11.7 billion out of Medicaid over four years. Congress rejected these proposals, but it still cut federal Medicaid funds by an additional $1 billion over the next four years, making the total Medicaid cut for fiscal year 1982 to fiscal year 1985 $4 billion.

Children have been hard hit by Medicaid cutbacks. A CDF national survey found that of state changes in health programs affecting mothers and children between October 1981 and August 1982 that every state had reduced its Medicaid program for mothers and children by cutting back on services or making eligibility more difficult to obtain, or both. Since October 1981:

An estimated 700,000 children lost AFDC. Many also lost Medicaid. In 22 states children losing AFDC have no alternative route to the Medicaid program. The Research Triangle Institute evaluation of the impact of the 1981 AFDC cutbacks found that over 44 percent of families losing welfare benefits as a result of the 1981 amendments reported no health insurance.

Seventeen states placed additional restrictions on Medicaid eligibility for children that were not required by Congress, including eliminating coverage for some or all categories of children between 18 and 21 years old and eliminating benefits for two-parent unemployed families. Thirty-one states reduced or eliminated Medicaid services of importance to mothers and children.

Finally, there is a substantial population of uninsured families and children in this country who are neither newly uninsured because of recent unemployment or newly distitute because of Medicaid and welfare cuts. In 1976, well before the recession, some 25 million persons in the United States, 38.4 percent of them children, were uninsured. Many reasons account for this uncovered status. Chief among them, for mothers and children, however, is the failure of Medicaid to reach more than a fraction of poor families because of low financial eligibility levels and the program's fundamentally inequitable eligibility criteria which provide for coverage only of children and mothers living in AFDC-related households.

Only eleven states in the country provide Medicaid to all women—married or not—who are unable to afford the cost of decent maternity care. In 12 states, single poor working women cannot qualify for Medicaid for first-time pregnancies. In 34 states, poor children cannot get Medicaid coverage for checkups and hospital care solely because they live in two-parent households. Some of these families are working families whose jobs pay little and carry no health insurance benefits. Nearly 13 percent of workers earning between $5,000 and $10,000 have no health insurance.

### BELEAGUERED TITLE V PROGRAM

For families that are uninsured or underinsured, there is a network of public health programs which provides care at free or reduced price levels. Many of these programs are located in medically underserved areas. The key health service program for the underserved within the jurisdication of the Senate Finance Committee is the Title V Maternal and Child Health Block Grant Act. In fiscal year 1982 the program was funded at $373 million, 18 percent below the fiscal year 1981 appropriations level. In fiscal year 1983, rejecting the Administration's proposal to merge the MCH Block Grant with the WIC program, and cut the combined funds by 35 percent, Congress appropriated $478 million through the Emergency Assistance "Jobs Bill." However, this amount is still 16 percent below the $572 million which the Congressional Budget Office estimates is needed to maintain 1980 real purchasing power in fiscal year 1983.

The state-by-state survey done by CDF revealed that in 1982 47 states cut their MCH Block Grant Program through restictions in eligibility or services. Forty-four states made these cuts by reducing prenatal and delivery services for pregnant women, and primary and preventive health care for infants, children, and women of childbearing age. Twenty-seven states achieved savings by cutting services for handicapped children. Every state that reported major changes in MCH eligibility or services also reported substantial and related cuts in their Medicaid program. The hope is that the infusion of additional funds in fiscal year 1983 from Congress will assist the states in repairing the program.

As damaging to the services provided mothers and children under the MCH Block Grant as the funding cuts have been, the unpredictable flow of federal dollars to the states over the last two fiscal years has led state MCH agencies to cut more drastically and to rebuild more cautiously when additional dollars have come from Washington or state legislatures.

### INCREASED NEEDS

Children need checkups and immunizations, get earaches and strep throat, and have accidents and life-threatening diseases and handicapping conditions regardless of whether or not their parents have jobs, or health insurance, or Washington cuts its budget. Clinics and hospitals (particularly public charity hospitals and children's hospitals) have seen their revenues shrink but their caseloads increase.

In Broward County, Florida, the Health Department is the only source of low-cost prenatal care in the county. At this time, there are no appointments available until September 1, and women are not being seen until their 4th month of pregnancy as the Department rations scarce care. Three hundred women delivered in the county hospital with no prenatal care, many on an emergency basis. When asked, the majority of these women stated they had tried to get care but none was available.

The Ann Arundel County Health Department in Maryland experiencod a 60 percent increase in patients in its maternity clinics in fiscal year 1982.

In the Alexandria, Virginia Health Department clinic there is a 3-4 month wait for an appointment, triple that of last year because many residents, especially those seeking prenatal and postnatal care, find they can no longer afford to see private doctors.

The Ohio Health Department reports that in one county use of free clinics has increased 100 percent. In 35 projects surveyed waiting time for an appointment increased 30-50 percent. Maternal and child health services are non-existent in 11 counties with the greatest primary care needs.

As a result of increased demands, scarce state dollars, and decreased third-party payments from Medicaid and private health insurance, providers are erecting barriers to health care for the uninsured. Common examples include the following:

To remain solvent, the University of Kentucky Medical Center has changed its admissions policies. In the past, about one-quarter of the people served were paid for by Medicaid, and 26 percent had no way to pay. The Center now restricts its Medicaid caseload to 15 percent and those unable to pay to 5 percent. This policy has meant many pregnant women have been refused prenatal care at the facility.

Cook County Hospital in Chicago, Illinois reports that the amount of dumping of Medicaid and uninsured patients from private Chicago hospitals has increased 400 percent since July 1981.

### THE ADMINISTRATION'S FISCAL YEAR 1984 BUDGET PROPOSALS

The Reagan Administration's health budget for fiscal year 1984 continues to weaken the underpinnings of the public health programs that are "the providers of last resort" for the uninsured and the poor—Medicaid, the Title V Maternal and Child Health Block Grant, Community and Migrant Health Centers, Family Planning, and WIC. The budget will also result in further cuts in health care for the poor by dismantling the AFDC cash assistance program, thus eliminating eligibility for Medicaid coverage. At a time when unemployment and loss of job-related health insurance is placing a greater demand on public health services, the Administration proposes cutting an additional $1.9 billion out of Medicaid in fiscal year 1984, 1985, and 1986 by further cutting federal funds to states already operating minimal programs and by resurrecting the costsharing proposal that was considered and rejected by Congress in 1982. Congress adopted a carefully developed compromise that gave states greater leeway to charge most patients, while protecting others whom Congress specifically found unable to pay—namely, pregnant women and children. The President's budget ignores Congress's decision.

Freezing Maternal and Child Health Block Grant appropriations at the federal year 1983 level. This is 18 percent below fiscal year 1981 appropriations. In addition, the Administration has proposed legislation to do away with funds set aside for research, training, and demonstration projects, and to undermine a longstanding national committment to maternal and child health by encouraging states to channel funds now spent on MCH to other purposes.

## AN ALTERNATIVE AGENDA

This Committee, under the leadership of Senator Dole, has made modest but important gains for mothers and children over the last two years.

The Omnibus Reconciliation Act of 1981 which gave states the flexibility to develop targeted medically needy programs for families not receiving cash assistance also required that any such program include maternity services for pregnant women and out-of-hospital care for children. One state has already responded by adding "medically needy" pregnant women and children to its Medicaid program, and several others are considering such an expansion.

In 1982, Congress exempted poor pregnant women and children covered by Medicaid from paying part of the cost of their care in order to encourage use of cost-effective preventive services.

This Committee also maintained its commitment to maternal and child health by creating the Maternal and Child Health Block Grant which built on federal and state commitments to maternal and child health put in place in 1935.

We urge you to add to your 1984 agenda the following critical actions:

Reject the Administration's proposal to further cut federal Medicaid funds, level-fund the Maternal and Child Health Block Grant and weaken the protections deliberately put in place by this Committee.

Address the worst inequities in Medicaid eligibility policies which cause millions of poor children and pregnant women to forego the benefits of health care. Pass Medicaid reforms to provide Medicaid to children and/or pregnant women in families solely on the basis of whether or not they are poor.

Provide automatic Medicaid eligibility for newborn babies. A recent survey conducted by the American Academy of Pediatrics found that in many states newborn babies eligible for Medicaid are being denied coverage simply because the state has no procedure for declaring them eligible at birth. As a result, some hospitals have turned away pregnant Medicaid recipients in labor for fear their babies' care would not be paid for.

In about half the states, only well-baby care after delivery is paid for under the mother's eligibility. In the other half, even well-baby care cannot be reimbursed without application for benefits for the newborn within a limited period of time. In almost one-third of the state programs, application for Medicaid benefits for an unborn child cannot be considered until after the birth of the baby. In about one-fourth of states, Medicaid eligible mothers must apply in person at a local welfare office for benefits for her newborn child.

Raise the authorization ceiling for the Maternal and Child Health Block Grant from $373 million to $478 million, the level at which the program is currently funded. This increase will maintain funding consistency critical to rational and cost-effective planning and provide states with ongoing support to assist communities hard hit by unemployment.

The MCH Block Grant is a companion program to the WIC program. The food supplements provided through WIC and the health and medical care provided by the MCH clinic are key for healthy babies and children. Each by itself not as effective an intervention.

## CHILD WELFARE AND OTHER SOCIAL SERVICES

The families and children harmed by recent cutbacks in the means tested entitlement programs are jeopardized as well by cutbacks in the Title XX Social Services Block Grant and Title IV–B Child Welfare Services Program. These programs fund a range of services for families in crisis situations, abused and neglected children, and children in foster homes and residential treatment centers. In addition to protective services, the Social Services Block Grant also provides critical funding for child care for low-income working parents. The Title XX Program has long been the major source of direct federal support for child care.

These two crucial service programs have been severely impacted by the budget cuts of the past two years. Services have been reduced as a result of the 21 percent decrease in funding for the Social Services Block Grant and the maintenance of the Child Welfare Services Program at slightly below its fiscal year 1981 funding level, at the same time that funding reductions in the key income support programs—AFDC, Medicaid, and Food Stamps, and increased pressures on families caused by the general decline of our economy have significantly increased the demand for child welfare and other social services.

We urge this Committee to reject the Administration's proposal to cut funds under the Social Services Block Grant by 10.5 percent, and to abolish the Community Services Block Grant and expect the range of services it provides—help to secure adequate housing, emergency assistance, and employment services—to be funded under the Social Services Block Grant. We also urge the Committee to reject the Administration's proposal to maintain the Title IV-B Child Welfare Services Program at $156.3 million for the third year in a row, and to allow the services program to be used for training while eliminating the $4 million currently available through the Child Welfare Training Program. Similarly we urge you, as you have in the past, to reject the Administration's proposal to eliminate the entitlement nature of the federal foster care program authorized under Title IV-E of the Social Security Act.

But, as in the other program areas discussed this morning, we must also ask that you go further. To help begin to address the overwhelming demand on social service agencies described below, and to allow agencies to better meet the needs of children and families for child care and other services, we urge you to increase the authorization for the Social Services Block Grant from $2.5 million to $2.8 billion for fiscal year 1984. $2.8 billion was the level included by the Senate in its version of the Emergency Assistance "Jobs Bill," and is only $75 million below the $225 million level finally provided to the states in that legislation. Without continued funding at a level above $2.5 billion, states will not be able to maintain the restorations in services they have begun to implement with the additional funds in the Jobs Bill.

To enable child welfare systems across the country to best meet increased demands from troubled families we also urge your continuing support for maintaining Public Law 96-272, The Adoption Assistance and Child Welfare Act of 1980, intact. Specifically, we urge you again not to cap the federal foster care program under title IV-E of the Social Security Act. As Congress recognized in enacting Public Law 96-272, an arbitrary cap on funding for out-of-home care will seriously jeopardize children unless simultaneous efforts are made to ensure that services are in place to ensure appropriate alternatives to foster care. Certainly at a time when the Child Welfare Services Program, Social Services Block Grant, and the child abuse program are suffering from two years of cutbacks one cannot assume that services for alternatives to foster care are in place. Nor does it make sense to impose a cap based on fiscal year 1982 funding levels, as the Administration proposes, when communities are experiencing real increases in the numbers of children entering care.

The restoration of funds for the Social Services Block Grant together with the maintenance of Public Law 96-272 will enable agencies to better respond to alarming reports of increases in child abuse and neglect; increased demands for foster care placements; and cutbacks in services to prevent family crises.

Consider just several examples.

A survey of child abuse specialists in all 50 states and the District of Columbia, conducted in the fall of 1982 by The National Committee for Prevention of Child Abuse, reported that 39 states had seen an increase in reported cases of abuse in the past year. Fifteen states said the number of confirmed reports was also increasing. Thirty-three states reported seeing more serious abuse, and 14 states said they were seeing more deaths due to abuse. Despite these figures, 32 states said there had also been noticeable cutbacks in child abuse programs.

In Philadelphia, general protective service reports of children needing protective services in October 1982 were double those of a year earlier. Fifty percent of the 136 new reports in October were directly attributable to economic factors—families with no heat, food, or place to live. A year ago workers in Philadelphia were getting three to five new cases a week. Now they are getting ten. Intake, which formerly averaged 10 to 12 cases a day, is averaging 30 a day. Although the city has seen a 50 percent increase in cases over the past year, there are at least 20 fewer workers to meet the needs of children and their families.

Dakota County, Minnesota, a county with a relatively high per capita income, witnessed a 23 percent increase in the number of child abuse reports between November 1981 and November 1982, in part attributable to increased economic pressures on families. About one-third of these reports, generally cases of more severe abuse than a year ago, prove serious enough to get subsequent services.

In Dallas, Texas, the county child welfare unit has experience a 26 percent increase in the number of children in foster care in the county—from 380 to 480—over the past 15 months. The children entering care are suffering from more serious conditions—burns, multiple fractures, and head injuries. Twenty percent of the children being placed have been in the state for less than a year.

The increase in Title XX funds will also help to alleviate the negative impact that cuts in the Social Services Block Grant and the economy generally have had on the availability of quality child care across the country. Maintaining the program at its 1975 funding level of $2.5 billion will deny children needed services.

Although Secretary Heckler herself has stated, in testimony before this very Committee, that the "availability of adequate day care is an essential element if welfare mothers or others with young children are to work," evidence from a number of states indicates that cutbacks in funding have severely diminished child care support for mothers who are working or are in training programs preparing them to work.

A CDF survey of Title XX child care policies in 36 states conducted earlier this year revealed that in the last two years seventeen states had restricted child care for mothers enrolled in training programs.

A June 1983 study of the effects of federal cuts and changes upon day care services in New York State, by the New York State Child Care Coordinating Council and Statewide Youth Advocacy, revealed that 12,000 fewer children will receive day care purchased by local social services districts in New York State in fiscal year 1983 than in 1981. Although some of these children may receive day care purchased from their parents' welfare grant, claims under Title IV–A in the counties outside of New York City have dropped 76 percent. Working poor families have been the most seriously affected. Thirty-four of the 57 upstate counties offer no income eligible day care to working families above the welfare level.

Delaware cut its Title XX funds targeted to child care by 50 percent. Mothers who attend college or post-high school training programs beyond one year are no longer eligible for subsidized care. The number of children served dropped from an average of 2,039 a month in fiscal year 1981 to 1,260.

Kansas reduced its share of Title XX funds targeted to child care. It stiffened eligibility for child care by lowering the income limit from 80 to 65 percent of median income and instituted a policy denying child care to parents in school or training.

Pennsylvania lowered its eligibility criteria from 115 to 90 percent of the state median income and imposed a $5 per week minimum fee for all families in fiscal year 1982. The number of children served went from about 24,000 in fiscal year 1981 to about 21,000 in fiscal year 1983.

As a result of the reductions in services or imposition of fees, children are being left alone or have been switched to less familiar, and often less supportive, child care arrangements.

In 1981, 739 West Virginia families lost child care. some 565 of these families responded to a questionnaire regarding their current child care arrangements. A total of 391 children had experienced some type of change in child care arrangements. At least 79 children were caring for themselves.

A Rhode Island child care center, located in a public housing project, had 22 children enrolled last year. Five children remain. The director reports that some children are being cared for by teenaged high school dropouts; others she watches hanging out on the nearby playground.

In Pittsburgh, a combination of Pennsylvania policies—including tighter eligibility criteria and fees for services—resulted in over 200 children losing child care services, 10 percent of the total number being served. Some parents quit work. One parent commented, "I'm forced to leave my child in the care of an unlicensed babysitter whom I don't trust as much as the licensed day care provider." Another mother says, "My children are no longer with me because I couldn't find day care. The children are with their grandparents." Many older children have been forced to stay home from school to care for preschool brothers and sisters.

A report by the Citizens Committee for Children of New York revealed that in New York City, center teachers and directors are seeing newly ineligible and financially strapped parents resorting to substandard, unlicensed, and unsupervised day care. These directors report that no quality alternatives to public day care exist for these families. "Day care available" signs have been seen in store fronts all over the

Bushwick section of Brooklyn. Directors report that children are being crowded into unsuitable, unlicensed facilities that are both unsafe and illegal. Such arrangements are increasing.

In many states, increased demands for care have been accompanied by reductions in staff and services, thereby jeopardizing the quality of care available to abused, homeless, neglected, and disturbed children, as well as children of working parents. Despite valiant efforts, few states have been able to fill the gap left by federal cutbacks.

Even states that have tried to cushion the impact of federal cuts are facing grave difficulties. Title XX cuts in some states have exceeded 21 percent, because the federal government no longer requires that states contribute $1 for every $3 in federal funds and maintain key protective services for children. Over 25 states tried to absorb Title XX cuts in the first year by transferring funds to the Social Services Block Grant from the Low-Income Home Energy Assistance Block Grant. Others used funds freed up by changes in AFDC to bolster social services. Still others as you have just heard imposed or raised fees for services or limited those who could participate in the program. Several states, including California, Florida, and New Jersey, used funds that were available under the Title IV–B Child Welfare Services Program (to prevent placement and develop alternatives to foster care) to offset federal Title XX cuts and meet the demand for increased state funds. Services to prevent abuse have been almost eliminated. Only the most critical abuse cases are dealt with.

States will not be able to maintain indefinitely these stopgap measures to minimize what in many states is a federal funding cut of approximately 25 percent. Numerous state officials warn that additional cuts in federal dollars will make it impossible to meet the increasing demand for services. Thus the continued restoration of funding for the Social Services Block Grant and full funding for both the Child Welfare Service Program and Title IV–E Foster Care and Adoption Assistance Programs are essential.

The Children's Defense Fund believes that the harms imposed by the hastily imposed, ill-conceived budget cuts of the past two years must be addressed immediately. We therefore ask you not only to reject any further cuts in AFDC, Medicaid, the Maternal and Child Health Block Grant, the Social Services Block Grant, and Child Welfare Services Program, but to enact minimal restorations in each of these programs as well.

We share the feelings of Mrs. Evelyn Davis a grandmother of 13 and great grandmother of six who has worked for 25 years from early morning to late at night to provide quality child care and support services to low-income children and families in Des Moines, Iowa. Mrs. Davis has not only fought for decent child care for the children she has served, but also for employment opportunities for their parents to help lift them out of poverty. As she watches these families constantly struggle harder and harder, Mrs. Davis' comments must be heeded: "Time doesn't stand still, we're losing a whole genration of children." We ask you, as you have done in the past, to act now to help us protect our next generation of adults. It is your leadership and courage that is so vitally needed.

Thank you.

## STATEMENT OF LEON GINSBERG, PH. D., COMMISSIONER, WEST VIRGINIA DEPARTMENT OF WELFARE, CHARLESTON, W. VA., PRESIDENT, AMERICAN PUBLIC WELFARE ASSOCIATION, WASHINGTON, D.C.

Dr. GINSBERG. Thank you. I appreciate this opportunity to testify in response to the administration's fiscal year 1984 budget proposals. I am Leon Ginsberg, Commissioner of the West Virginia Department of Human Services, and president of the American Public Welfare Association. I am testifying today on behalf of our Association's National Council of State Public Welfare Administrators. The council represents the gubernatorial appointees and other State executives who are responsible for the administration of medicaid, AFDC, child support enforcement, social services, and other human services programs.

The written statement which I have submitted in multiple copies, and which I will summarize here, describes for you a plan that was developed by our State administrators to make many needed improvements in the operation of our Nation's welfare system. It consists of proposals drawn or derived from three sources: recommendations developed by the State human service agencies; legislation introduced by members of Congress this year; and the administration's fiscal year 1984 budget. We believe that the plan we present represents a workable, fiscally prudent and politically feasible alternative deserving your closest scrutiny.

We advance three objectives. First, to simplify and reduce the expense of administration by repealing or relaxing Federal requirements that are not cost effective; second, to enhance equity by eliminating or modifying policies that draw inappropriate distinctions among program recipients; and, third, to increase the adequacy of benefits and services by filling the most critical gaps in the protection afforded by the Nation's social safety net.

In the time remaining I will briefly highlight the key features of our plan. First, it includes a number of relatively modest adjustments in the aid to families with dependent children program. Some of the AFDC changes we recommend seek to remedy problems that have emerged as we have implemented the program revisions required by the Omnibus Budget Reconciliation Act of 1981. Most of these problems were unanticipated at the time that they were enacted, and can be corrected with simple, non-budgetary changes in the law. However, there are a few, particularly in the areas of work, that cannot be resolved without the expenditure of some additional funds, although we think the added cost is small compared to the benefits contained in our recommendations.

The other AFDC proposals in the State administrators' plan address statutory barriers to effective and efficient management. Let me just give you a couple of brief examples.

First, we propose letting the States test alternatives to the AFDC program for two-parent families where eligibility is based on the unemployment of one of the parents. During this era of fiscal constraints, current Federal standards for the AFDC—Unemployed Parent Program, as it is called—have made this option too expensive for several States, and they have had to drop out. Loosening those standards some, say, by allowing imposition of a time limit on assistance or eliminating the child care deduction for working parents would probably make it possible for more States to use this option, either once again for the States that have had to drop it, or for the first time for about half of the States that have never had it, since they could design it as a form of temporary assistance with strong work incentives and requirements.

We are also suggesting letting the States, on a demonstration basis, consolidate administration of the AFDC and the food stamp programs. There are unnecessary differences in the policies and procedures of the two programs, and these are perhaps the major source of complexity in administration of welfare programs. Demonstrating this in a limited number of States would permit the Federal Government to accumulate the information it needs to determine what statutory and regulatory changes are needed to assure consistent administrative performance across the programs.

H.R. 2653 has been introduced in the House by Representative Carroll Campbell to allow up to eight States and localities to demonstrate the exact thing that we are talking about here.

Others of our changes seek to increase the ability of States to move welfare recipients into gainful employment, expand educational and work opportunities for older children, improve program efficiency, and enhance the responsiveness of AFDC to recipient needs.

In medicaid, we offer a small set of changes designed to strengthen the State's cost containment efforts and to shore up our ability to cover women and children. The cost containment proposals include giving States some flexibility in requiring copayments of medicaid recipients—we have less now than we had 5 years ago; making State efforts to obtain reimbursement from third-party payors a priority for Federal funding; simplifying the requirement that patients in skilled nursing and intermediate care facilities be recertified by a physician every 60 days: allowing States to make annual investigations and reports by medical review teams of skilled nursing and intermediate care facilities by sampling rather than checking each patient record; and requiring medicaid applicants to assign their health insurance rights to the State as a condition of eligibility, which would simplify our collections from these third parties.

While cost issues have dominated the medicaid debate in recent years, it is essential that we not overlook the gap which continue to exist in health care for needy Americans. Given the tremendous pressures on all levels of government to curb spending, it is unlikely that we can fill all these gaps at once, but a start can be made by agreeing to the following improvements in coverage for women and children.

First, let the States provide medicaid coverage to low-income children and their working mothers who have lost AFDC coverage because of the earnings disregard changes which were made in the 1981 legislation. And, second, allow the States to provide services under medicaid to children and pregnant women whose income has fallen below 55 percent of the Federal poverty line. Some funds have been provided in both the House and the Senate budget resolutions to initiate this coverage.

Finally, let me mention social services. Our plan calls on Congress to give serious consideration to modest funding increases for programs such as title XX, the Social Services Block Grant, and title IV-B, Child Welfare Services, through which States can respond effectively to the increased needs generated by the recession and the long-term social problems with which our society has not yet come to grips.

We also suggest fine tuning certain features of Public Law 96-272, the Adoption Assistance and Child Welfare Act of 1980, which provides incentives to States to secure permanent homes for children at risk. We think these will enable the States to better carry out their responsibilities under the law.

The Nation's welfare administrators believe the proposals that I have just sketched and the others that appear in my written statement mesh well with the fiscal strengency and political caution of the times, while preserving our society's important public commitment to a sound welfare system for the poor.

That concludes my testimony, Mr. Chairman. I thank you for the opportunity to speak before you.

The CHAIRMAN. Thank you. Senator Danforth?

Senator DANFORTH. No questions, Mr. Chairman.

The CHAIRMAN. Senator Chafee?

Senator CHAFEE. Yes; I would like to ask the panelists an overall philosophical question. Dr. Ginsberg, on page two of your statement, you touch on a matter that seems to me is with us and is going to continue to be with us. I would like your reactions to this, too, Miss Allen. You say:

> The number of households headed by women—one of the groups most likely to be poor and in need of public assistance—grows unchecked, as does the number of out-of-wedlock births. The latter is a phenomenon which has reached serious proportions among teenage mothers, many of whom are likely to become chronically dependent on welfare.

Unfortunately, as we look at the social scene in America, I would suggest that both of these occurences will continue to rise. We have got a problem that is going to continue to increase the funding requirements of the programs that you each are interested in. Do you see any way out of this morass, this extremely discouraging situation, Dr. Ginsberg?

Dr. GINSBERG. Well, it is a——

Senator CHAFEE. For example, I think there are some statistics—something to the effect that 55 or 60 percent of the children born in Washington, D.C., are born out of wedlock.

Dr. GINSBERG. Right; I have seen that statistic, too, and I don't know the source either. But I have seen it. There are a couple of observations I would make. One is that this kind of a worldwide phenomenon, the birth of children to single women, it follows a pattern that began earlier I think in Western Europe, and it may be less a social problem than a social fact, a fact about family life and child birth and education, changing in our country in ways that are rather significant. I think in the 10 years from 1970 to 1980 the number of children living with a single parent—a woman—at least doubled, but so did the number of children living with a single parent—a mother—because of divorce. And so did the number of children living with a single parent who is a father. So we have a phenomenon in which the single-parent family is becoming not the prevailing situation but more and more common, and the experience of more and more children in our society.

The number who are receiving assistance is relatively small. The number who are self-supporting or are supported by a former spouse is relatively large. I think it may reflect at least temporarily and perhaps in the longrun a change in the way family life operates in the United States, or in our definitions of the family. I think it is important that we understand the public welfare implications because it cost money to care for these children. But the welfare expenditure is a relatively minor part of the budget and a relatively minor part of the problem.

Senator CHAFEE. Of what budget?

Dr. GINSBERG. Of the Federal budget and even the budget for money spent on human services in the country as a whole.

Senator CHAFEE. What do you have to say. Miss Allen?

Miss ALLEN. I think the Children's Defense Fund is certainly concerned about the issue that you referred to. I think we are particularly concerned when you look back and see that today there are 2.5 million more children living in poverty than there were two years ago, a very troubling fact. Certainly the recommendations that we have made this morning, many of which represent an investment in prevention, either in the social services, child welfare, or medical areas, will help to address the needs of the next generation of children coming forth. I think that within the various programs as well, we are looking to the creation of education and job training to prepare this next generation of youth to address the problems before them. These are the sorts of things that are needed. There are additional things on a number of fronts that the Children's Defense Fund is trying to address.

Senator CHAFEE. Well, we appreciate what both of you are doing in this area. Your statements are very helpful because they contain specifics. The thing that we find most helpful, at least I do up here, is when people can tell us exactly what they are seeking instead of just requesting more money—that is a given. However, we would like to have a little more specifics on it. Well, thank you both very much for your testimony. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Wallop?

Senator WALLOP. No questions, Mr. Chairman.

The CHAIRMAN. Senator Long?

Senator LONG. No questions.

The CHAIRMAN. I would just make an observation, first. In Dr. Ginsberg's testimony he mentions the, Carroll Campbell bill in the House which would coordinate food stamps and AFDC. That seems to me to be a good idea. I am chairman of the Nutrition Subcommittee of the Agricultural Committee which deals with food stamps, the WIC program, and the school lunch program. And I assume that your suggestion would not only result in better administration but might even save some money on the administrative side that might be used in other areas.

Dr. GINSBERG. Yes, sir, I think the problem we have is in the States, and my written testimony gets into this in great detail. In the States, the food stamp and AFDC programs are run by the same agencies and done by the same workers. And they have to go through double eligibility determinations under different rules to provide these services to the same client. And if we just standardized the two programs—they are really not that different—that would not make that much difference in eligibility. We could save administrative money and reduce errors. If we found somebody who was fradulent in one program, we would likely be able to keep him off the rolls in both rather quickly. And we could get by with the number of employees we have rather than adding people. So we think that would be a reasonable approach to the food stamp and AFDC administration problems, but we thought we would demonstrate it first if we could.

The CHAIRMAN. I was just checking to see what the error rate is now. It is fairly high in AFDC and fairly high in food stamps. I know the administration has suggested that it might be reduced to even zero. I am not certain you can ever reduce it to zero. Somebody might make a mistake somewhere.

Dr. GINSBERG. The client might lie to us. That happens occasionally.

The CHAIRMAN. Right; but I guess that is counted as an error.

Dr. GINSBERG. Yes, sir, that is. Yes; a client error is counted there. And a majority of the errors are client errors, but they are counted as errors as if the agency made them.

The CHAIRMAN. Well, that is an idea that I certainly will pursue. It seems to me that it makes some good commonsense.

I want to ask one question of Miss Allen. As far as I can tell your statement doesn't say anything about making fathers pay for child support. We have had a number of articles recently telling about how delinquent fathers just escape the obligation to support their children. And I guess if we assume that we can't make them pay then maybe the Federal Government and the States have an obligation.

Jane Bryant Quinn, for example, writes "Delinquent dads have condemned millions of children to the welfare roles." My question is, Do you agree that we ought to first try to get the father to support the children before we ask the general taxpayer to do that?

Miss ALLEN. Certainly the issue of enforcement of child support obligation under the IV-D program both for AFDC and nonAFDC families is something that the Children's Defense Fund has looked at and followed the lead of other organizations. We are also in connection with the child support provisions in the Economic Equity Act looking at, with interest, some of the various provisions being implemented across the country to try to address the issue of enforcement of child support.

The CHAIRMAN. Well, I know that is a matter in which Senator Long has had a longstanding interest. Others of us have, too. It seems to us that before we ask somebody to cough up the money, we ought to first make certain that the father, if he is able, and if he can be located, should support his children.

Dr. GINSBERG. In my prepared testimony, again we deal with that program, with the title IV-D program, which Senator Long was instrumental in initiating. And there has been a proposal that there be a reduction in Federal funding for it. There actually was last year. We have asked that there be no major changes in it now, because it is an important way to support children who ought to be supported by their fathers.

Senator LONG. Could I just comment on that for a moment?

The CHAIRMAN. Sure.

Senator LONG. According to the statement you have here, and I think that is also my understanding, we are collecting almost three times as much money in child support as we are spending on collecting it. As long as the expenditure for child support is less than the amount that we are taking in, it seems to me that we clearly have not reached the point of diminishing returns. As a taxpayer, I would rather pay the money to make some man who refuses to do his part do his duty, rather than to take the view that unless I can make a two-for-one profit out of it I am not going to do it. Because even if it is only a dollar-for-dollar exchange, it is far better that you go out there and make the father do his duty. There are other fathers who are going to do their part voluntarily because they know that they would be made to do it otherwise.

You can compare this situation to the way it was back in the armed services when you were drafted to go serve. Great numbers of people volunteered in my part of the country. Most of them would volunteer before they were drafted—but if they hadn't volunteered, they would would have been drafted. They knew where their name was on the list, so they thought, if they were going to be drafted anyway, they might as well volunteer.

The same logic tends to apply where people know that they are going to be made to do something, for example that they are going to have to contribute to the support of their children. On the other hand, if they think they are going to get away with not contributing, that kind of behavior is going to multiply.

Dr. GINSBERG. I absolutely agree, Senator. What we have found is a couple of things. One is that once we find a father and start him paying, and he is threatened with all kinds of penalties, including a jail sentence, it kind of makes a believer out of him and he keeps on paying maybe years and years in the future. We never have to worry about it anymore and his family is permanently off the rolls. So that initial investment, which in some States is less than a dollar gained for a dollar expended, probably is much better than this in the long term.

Senator LONG. In other words, there is no computation in any of this as to how much money you save because you would have gone after that father, and he knew you were going to go after him in the event he didn't make his payments. In affluent families, in upper middle income families, you don't have much of a problem because those fathers know that if they don't pay, people are going to go after them.

As I have said here many times, I was a poverty lawyer back before the Government started paying poverty lawyers. I found that when some fellow would come to me and he didn't want to pay, he always felt that if his wife got any tougher about that matter, he would just leave that jurisdiction, and she would have no recourse.

That is why it seems to me so important to have in the law that she doesn't have to be on the AFDC rolls for the Government to come to her aid. Society ought to rally behind that mother who is trying to get support for those children.

When I was a poverty lawyer, I had no way to represent such a father who wanted to avoid paying support. I didn't go to court with him, but I have heard such a person say he was going to leave the area, just get going, and I have seen them do it. To me it seemed a travesty for the Federal Government to say, oh, we can't get involved in something like this, the States ought to do it. Because when he had crossed that State boundary, the State that was concerned about it could no longer reach him. The Federal Government in that kind of situation ought to do its part to help. If we work together on this matter, we can enormously reduce these rolls.

It seems to me that we could achieve about twice what we have done if we are willing to put the effort into it. Do you feel that way about it, Dr. Ginsberg?

Dr. **Ginsberg**. We do pursue parents who are not on the AFDC rolls. We have to; every State has to, or we don't get the Federal matching. And we have an interstate computer system which we use to trace a guy with social security numbers into other States. The other thing that has helped a lot in the last couple of years is an income tax intercept. We can collect their income tax refund before it gets to the delinquent father, and we pay it back to the State or pay it to the family, as the case may be. And we are doing that in our State now with State income tax returns. I think it is just a logical program. I think it is a remarkable program and we are all pleased with it, and don't want to see it hurt in any way.

Senator **Long**. When the administration makes proposals for economy, in the child support program, that part of the program that relates to identifying the father is just treated the same as anything else. It gets no priority or special consideration. I would like to ask you, isn't determining paternity one of the essential things that has to be done before you can determine whether a man ought to support that child? You really need to know who the father is before you can make him pay his contribution.

There is no way you can proceed unless you know who the father is. Shouldn't the expenditure to determine the identity of the father claim some sort of a priority?

Dr. **Ginsberg**. Again, by procedure and by law, we have to, first of all, try to establish paternity, if that is in question. The woman has to, cooperate with us in helping find the father. That is a precondition for receiving assistance, unless she has good reason to believe that she would be in danger from a violent father. But in routine cases, the mother has to help us find the father. And she cannot lie about it. And if she does, we can take her off of the assistance program. And she has to define who the father of the child is. And we also are using some new tests—and I don't know the names of them any more—at various medical facilities which now establish paternity a lot more effectively than was possible 10 years ago.

So these are major parts of the public welfare program in the country now.

Senator **Long**. What percentage of the mothers who apply say to you that they are not going to tell what they know about paternity because they are afraid the man might be violent?

Dr. **Ginsberg**. If it was 1 percent I would be surprised, sir. The only reason that I know that it happens at all is because we got sued by a poverty lawyer and had to change our rules. And that is where those rules come from, is because of one woman who had a pretty legitimate case. But it is an infinitestimal part of the number of people who apply; almost nobody.

Senator **Long**. Well, at least we have made a great deal of headway. Not near enough, but when I look back at all the people we have had to fight, we have done pretty well. We have had to fight the department to make them do what seems to me that any taxpayer would insist on. They didn't even want to tell us what they knew based on what was right there in their own files. And then we had to fight the Internal Revenue Service to make them tell us what they knew, just to make them cooperate. Then we had to go to war with the U.S. Army. They wanted to be a safe harbor for all runaway papas—join the Army and you won't have to pay child support.

We have had to fight practically everybody, from the Army on down, to put the government on the side of the mother and the children. But I think that most of that work has now been done. We would appreciate any advice you could give us on ways we can do it more effectively. And we thank you for your statement.

Dr. **Ginsberg**. Thank you, Senator.

The **Chairman**. I have one other question of Miss Allen. Is there any area—I know some find it easy to criticize the Administration—do you find any area that we can save money in any of these programs? There ought to be some, even a dime, or a nickel, or a dollar somewhere.

Ms. **Allen**. Well, I would think that certainly with some of the changes that Senator Dole, this committee has supported in the health area, by preventing prenatal problems of children and also providing early care for children, that you, in essence, do save money in the long run. And I think certainly that, information in our testimony today supports the benefits of positive investments in early intervention in the health and social services areas.

The **Chairman**. But I think it is a little naive to suggest that you just have to keep every dollar in every program. That there is no waste or no misuse of program funds. It seems to me it is more credible to say that there are programs that we ought to scrutinize and other programs that ought to be expanded. I think we have to shake up the priorities. Everybody has a vested interest. They don't want to change their program. They don't want the other program expanded if it takes away from their program. My view is that with the scarcity of Federal and State dollars, and with the deficits facing us, we have got to have your cooperation to cut out the waste and the fat, if there is fat. In other areas we may need to add some funds because there are programs that are being starved because we are running out of money. So if you can give me a little list it would be helpful.

Ms. **Allen**. OK. We certainly, in our testimony, have included some priority programs which do not include all of those under the committee's jurisdiction. And we would be happy to discuss any of those in more detail.

The **Chairman**. Thank you very much. We appreciate it.

Our next panel will be James Hacking, who has been before our committee a number of times. Jim, we are happy to have you back. And Mr. William Hutton, executive director of the National Council of Senior Citizens. And we have had Mr. Hutton before. It is good to see you again.

Senator **Chafee**. All right. Why don't you proceed, Mr. Hacking.

[The prepared written statement of Dr. Ginsberg follows:]

## TESTIMONY OF LEON H. GINSBERG, PH. D., COMMISSIONER, WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES, AND PRESIDENT, AMERICAN PUBLIC WELFARE ASSOCIATION

### INTRODUCTION

My name is Leon Ginsberg, and I am commissioner of the West Virginia Department of Human Services. I also have the privilege of serving as president of the American Public Welfare Association. Today, I am testifying on behalf of the National Council of State Public Welfare Administrators, an affiliate of the Association. The Council represents the gubernatorial appointees and other state executives responsible for the administration of many of the human service programs within the jurisdiction of the Senate Finance Committee.

The purpose of my testimony is to set forth for you a practical and fiscally prudent plan to finetune the nation's welfare system. The elements of our plan cover aid to families wih dependent children (AFDC), child support enforcement, Medicaid, maternal and child health, social services, and foster care and adoption assistance. We have drawn from a variety of sources—including the administration's fiscal year 1984 budget recommendations—to construct a set of proposals that will strengthen the ability of these programs to meet the objectives which Congress has set for them. The state administrators have been motivated by the conviction that the financial problems plaguing all levels of government today must not be allowed to blind us to the opportunities for effecting constructive, incremental change in the services and benefits that we provide to people in need. Those of us in public service must not be forced by the economic and political uncertainty of the time to retreat from pursuit of the responsibilities with which the public has entrusted us. If major reform is not possible, then let us achieve what progress we can within the resources available.

The need for our plan, or something like it, cannot be disputed when one looks at the social problems facing the nation. Social tensions produced by the recession have not abated, even as the economic recovery begins. The incidences of child abuse, alcoholism, and drug abuse are up. There are more homeless people, including many intact families for the first time since the depression. More people are standing in lines at soup kitchens and food pantries. The problems are showing up in the growing demand for welfare benefits. Despite a steady stream of budget-cutting the past two years, the AFDC rolls have risen by close to 200,000 cases since last June. The number of two-parent families receiving AFDC is almost 18 percent higher than it was last year, as workers exhaust their unemployment benefits. The costs incurred by state and local governments for general assistance have grown by perhaps as much as 20 percent since fiscal year 1981, according to our own survey of the states.

At the same time, long-term social problems persist. The number of households headed by women—one of the groups most likely to be poor and in need of public assistance—grows unchecked, as does the number of out-of-wedlock births. The latter is a phenomenon which has reached serious proportions among teenage-mothers, many of whom, data show, are likely to become chronically dependent on welfare. Exacerbating the problem is the fact that little more than a third of the women living alone with their children receive child support from the fathers of those children. Some 27 million people, including many of those I have just mentioned, lack any kind of health care coverage.

Such strains in the social fabric of the nation will not be eliminated today, tomorrow, or probably even in our lifetime. Yet, are we not morally obligated to try? Is there not a prominent, continung role for positive government in overcoming the barriers that stand in the way to an adequate standard of living for all our citizens? The Council beleives there is, and offers its plan as a feasible step in that direction. This plan seeks to make the welfare system at least a bit more efficient, equitable, effective, and reliable than it now is. Making progress a step at a time—though it may not satisfy anyone's desire to overhaul the so-called welfare mess in one fell swoop—is at least politically achievable, and may actually in the long-run be the one best way to sustain the nation's commitment to meeting human need.

The state administrators' plan represents a composite consisting of: (1) some of the administration's fiscal year 1984 proposals, (2) amendments that have been offered by members of Congress this year, and (3) recommendations from the state human service agencies themselves. Given the deep cuts sustained by welfare programs the past two years, state administrators have rejected many of the current administration suggestions for achieving further savings in AFDC, child support enforcement, Medicaid, and child welfare services. However, those of its proposals that would, in our judgment, increase equity in the treatment of recipients without creating undue hardship or that would help to streamline program operations have been included in our plan. Legislative initiatives that have been undertaken this year to offset some of the more serious ill effects of the policy changes made since 1981 have also been incorporated. Finally, we have ourselves developed a series of modest adjustments, intended to enhance the workability of the AFDC, Medicaid, and child welfare programs, recognizing the need for cost control and improved program effectiveness in these areas. All told, we believe this package as a whole will provide long-run benefits that outweigh the modest net cost required initially to put it into effect.

## INCOME MAINTENANCE

I would like to begin the presentation of our plan by discussing those provisions that address income maintenance.

Let me first take up aid to families with dependent children (AFDC). No program has posed a greater challenge to us in trying to identify sound recommendations for improvement, given the sweeping reforms made by the 1981 reconciliation legislation. The state administrators believe that many of the changes achieved by that act make sense and should be preserved, but that many others warrant adjustment if the program is to operate efficiently and effectively. Our plan incorporates the necessary adjustments and adds to them some futher modifications designed to minimize the long-run costs to government of the current fragmented welfare system.

Specifically, we call for legislation that would address the following objectives: (1) make the administrative requirements of the AFDC and food stamp programs more compatible, (2) increase the ability of states to move welfare recipients into gainful employment, (3) expand educational and work opportunities for older children, (4) improve program efficiency through certain technical changes, and (5) enhance the responsiveness of AFDC to real need. I will discuss our specific proposals in connection with each of these objectives.

### MAKE AFDC AND FOOD STAMPS MORE ADMINISTRATIVELY COMPATIBLE

For years, we have tried through legislation and administrative action to align the policies and procedures in AFDC and food stamps. Some progress has been made but more can be done. Unlike the federal government, states operate these two programs through the same administrative structure, since so many families qualify for both benefits. Yet, our workers must master two different and often inconsistent sets of rules—a situation which in no small way contributes to the potential for error and waste. To reduce this potential and increase the efficiency of benefit delivery, further legislative changes are needed to coordinate AFDC and food stamp policies. The state administrators offer the following suggestions for your consideration:

Allow five states to test, on a demonstration basis, common definitions and income budgeting procedures in AFDC, food stamps (including beneficiaries not receiving cash assistance), and Medicaid (because of its close link to AFDC). Although some demonstrations have been conducted in the past, none have been sufficiently comprehensive to allow states to effectively integrate the rules of the three programs. Moreover, the federal agencies that administer the programs have often been reluctant, even in demonstrations, to change their rules to allow more compatibility with each other. Our proposal aims to determine the value of making policies for the three programs more alike. Demonstration states would be permitted to adopt any of the existing rules in each of the three programs as the standard for any of the other programs. This could include developing common terms such as income, resource, and household definitions; establishing uniform application and eligibility determination procedures; unifying the recipient budgeting and reporting processes for the three programs; setting up a single family case file; and consolidating program planning and evaluation.

Allow states to exempt from the AFDC resource limit—as is already done in food stamps—burial plots, funeral agreements, and property a family is making a good faith effort to sell at a reasonable cost. Currently, states must count these items, which are usually of little value and which may require a more costly administrative effort to locate and assess their value than they are worth. Exempting them would be a non-controversial change with virtually no effect on the federal budget and would bring AFDC into line, not only with food stamps, but also with supplemental security income.

Adopt for AFDC, the food stamp policy governing the treatment of strikers. At present, states must deny AFDC to the family when one of the parents goes on strike; if another family member (besides the parent) goes on strike, that person must be denied aid. Thus, in effect, AFDC is used to discourage recipients from participating in a strike, even if a recipient has no real alternative. By contrast, the food stamp policy simply prohibits a family's benefit from increasing when a member goes on strike (i.e., the benefit stays at the pre-strike level, rather than increasing to offset the loss of earnings). AFDC should operate in the same neutral way.

Replace the $75/month work expense disregard for AFDC recipients with the food stamp disregard of 18 percent of gross earnings. State welfare administrators have long advocated a percentage disregard, because it would be significantly easier to administer and more responsive to actual changes in the costs of working. In addition to being arbitrary, the $75 deduction is insufficient to cover even mandatory payroll deductions in states. The AFDC program would be well served by following the food stamp example in this area.

Remove the $25/month cap on the expenses for which participants in community work experience programs (workfare) may be reimbursed. This arbitrary cap, which has been imposed by regulation, may often be too little to cover the costs of transportation, day care, work clothes, and the like. States may supply these services directly and receive 50 percent administrative reimbursement, but this can easily turn out to be more expensive and administratively cumbersome than letting the participant purchase these things on his own, within reasonable limits set by the state. Under the food stamp workfare progrm, all reasonable expenses are reimbursable. A similar policy in AFDC would likely make CWEP a more attractive, cost-effective option for the states.

*Increase the ability of States to move welfare recipients into gainful employment*

No issue in the operation of the AFDC program stirs more controversy than the work behavior of recipients. In a sense this is surprising, since the large majority of recipients are children below working age and mothers from whom we do not require a work effort outside the home. The popular conception of AFDC, however, seems to largely be shaped by the relatively small group who we expect to work and to use the program as only the most temporary from of assistance. To help reduce this group's dependency on welfare, the 1981 reconciliation legislation granted states three new options: (1) CWEP of workfare, in which recipients are required to work in public or nonprofit jobs for their benefits, (2) Work Incentive (WIN) program demonstrations, in which state welfare agencies have flexibility in designing and operating the program, and (3) work supplementation, in which the AFDC benefit can be used as a partial wage subsidy. The Tax Equity and Fiscal Responsibility Act of 1982 added a fourth option, by allowing states to require job search of AFDC applicants and recipients.

States have taken advantage of these options in responsible and expeditious ways. Some 27 states have instituted workfare programs, most on a trial basis to determine whether this strategy can be carried out in a cost-effective manner. WIN demonstrations are underway or planned in 18 states. A few states are moving closer to implementing work supplementation programs, although restrictions in the federal law and regulations continue to be a major impediment to more widespread adoption of this promising technique. And structured job search and job clubs are part of the employment strategy in several states.

Since the states are making rapid progress, and since we are still discovering the relative strengths and weaknesses of the different approaches to work for welfare recipients, it would be extremely shortsighted in our view to mandate any particular approach at this time. My department, for example operates an AFDC workfare program. So far it seems to be working well, and we hope that it will become one of the more important vehicles by which some dependent adults can gain a foothold in the labor market. But we are only one state, and our experience is still far too limited for drawing reliable conclusions about the cost-effectiveness of this technique. I am sure that most, if not all, of the other 26 states testing this option would say the same thing. There are simply too many questions yet to be answered about the cost of operating workfare and the value of the work experience gained by participants to say definitively what this approach can achieve in the way of employability and welfare savings. Thus, we urge you to do as you have done before and reject the administration's proposal for mandatory workfare and job search.

As an alternative, the welfare administrators ask you to make the following changes in law, as a way to enable states to better meet their responsibilities:

Allow states to operate demonstrations to test variations of the existing optional AFDC program for two-parent families where a parent is unemployed. Congress created this option to discourage parents from separating as a way for the mother and children to qualify for aid. Today, only 23 states provide AFDC-UP, as it is called, with fiscal problems having forced four states—Missouri, Montana, Utah, and Washington—to drop the option during the past two years. To encourage states not now offering this important program to provide some assistance to two-parent families, to allow states to apply tougher work requirements and incentives to these families, and to give financially strapped states that may be forced to drop it an alternative to doing so, the federal requirements for AFDC-UP should be changed to give states more flexibility in this program component. This might include letting states: place a limit on the provision of aid as an incentive for the family breadwinner to return to the labor force quickly, eliminate the child care deduction or the work incentive disregard for these families, mandate participation in work supplementation programs (it is now voluntary), limit aid to certain geographic areas within a state, and open access to AFDC–UP for a limited interval during sustained periods of high unemployment. We believe such changes will allow states to help truly needy intact families with temporary cash assistance and strong work incentives and requirements.

Permit states to require a parent whose youngest child is age three or above to participate in WIN, if child care and adequate federal WIN funds are available. To avoid long-term dependency, it is crucial that parents become involved in work as early as possible, so long as the child's care is assured. Young mothers in particular may benefit from training and exposure to the world of work early on. The administration has proposed a similar change in the law.

Remove the four-month limit on the availability of the work incentive disregard ($30 plus ⅓ of net earnings). This arbitrary limit bears no relationship to any evidence of how long it may take a recipient to form an attachment to the labor force and move off the rolls without a loss in income. A recent study by the Research Triangle Institute for the HHS Office of Family Assistance claims that the limit has had no effect on the work efforts of recipients. Unfortunately, this study is unable to draw any conclusions about the material well-being of those families that left assistance once the work incentive was shut off, or that have not bothered to apply because their low level of earnings is higher than the even lower income cutoff point now used in AFDC. We believe that the income of many of these families falls well below the federal poverty line and that a substantial number have no form of health care coverage now that Medicaid is unavailable to them. The data on the effects of the four-month limit merely confirm that people will work under adverse circumstances, not that they have extricated themselves from poverty.

When calculating AFDC eligibility and benefits, require that the disregard for day care expenses be deducted last. Currently, day care costs up to $260/month per child are deducted and then one-third of any remaining income is disregarded as a work incentive, before AFDC benefits are calculated. This means that the higher a family's day care expenses, the smaller its work incentive. In other words, the work incentive is used to pay part of the day care cost—an effect we believe that Congress did not intend when it enacted the current policy as part of the 1981 reconciliation legislation. This policy also creates a serious inequity, because families who do not pay for their day care but receive it instead as a public service from Title XX or another program or from relatives and friends, get the benefit of a full work incentive since no day care expenses are deducted from their income. Disregarding day care last means that the work incentive will be applied equally to all employed recipients and that no family will be unfairly disadvantaged when it pays for day care out of its own pocket.

Allow states to penalize recipients who voluntarily quit or reduce employment. This proposal by the administration would extend the penalty in current law to cover persons who are exempt from participation in the WIN program because they work over 30 hours a week or live in a remote area. States firmly believe there should be effective means to enforce the work requirements of the AFDC program.

*Increase educational and work opportunities for older children*

Recently, a series of national reports have galvanized public attention on the critical need to improve our educational system. This development is of particular import to AFDC children, whose poverty is perhaps the single greatest barrier preventing them from taking advantage of the opportunities for upward mobility in our society. The state administrators believe that as improvements are made in the nation's schools, comparable adjustments need to occur in the policies governing AFDC. The program should do what it can within its limited domain to encourage the development of children and help break the cycle of intergenerational welfare dependency. In this regard, our plan includes two recommendations:

Allow any full-time secondary (i.e., high or vocational) school student to continue receiving AFDC through age twenty. Currently, eligibility may be extended through age 18 or up to age 19 if the child is expected to graduate from high school that year.

This rule discriminates against children who start their education late or who are held back for a time owing to slow development or illness. Our proposal would remove this bias but stop short of allowing AFDC to be used while a child attends college, which was the policy prior to 1981. We believe this approach will encourage children to finish their secondary education.

Exclude the earnings of any child in school from the gross income eligibility limit of 150 percent of the state's standard of need. At present, states must count a child's earnings toward the gross income limit for eligibility determination purposes but exempt them when calculating the family's benefit level. This creates an unnecessary and unintended inequity that may dissuade children of working age and in school from developing an early attachment to the labor force, when that may be the one thing they need to avoid future welfare dependency. A precedent for our proposal is contained in the Job Training Partnership Act (JTPA) enacted last year—it permits the exclusion for a time of the income earned by children in federally funded JTPA jobs. We see no reason not to extend this policy to the earnings of all children.

*Improve program efficiency through technical changes*

There are a number of technical changes that we believe could be made to simplify administration of the AFDC program without adding to federal costs.

Eliminate the requirement that pregnant women register for work or training when they are in their third trimester of pregnancy. We think this is an unintended quirk in the law. It makes no sense to require work registration by a woman who will soon be exempt from the requirement anyway, especially since few job opportunities exist for pregnant women and there are more productive ways to spend states' limited administrative resources. Although these women can be exempted now on the basis of incapacity, the states believe it is inappropriate to label pregnancy in this way.

When a family becomes ineligible owning to receipt of lump sum income, allow states to reinstate eligibility if the family's circumstances change. Under current law, the lump sum is divided by the state's monthly payment standard to arrive at the number of months of ineligibility. Even if the family's circumstances change—say, a child is born or a parent loses a job-during the period of disqualification, the family remains ineligible. Thus, current policy pretends no change occurs. The only exception to this is if the family is faced with life-threatening circumstances. Allowing eligibility to resume when the family's needs sufficiently increase would be much more equitable and less complex than having to define life-threatening circumstances.

Exempt the earned income tax credit (EITC) from countable income in AFDC. States are now required to count the EITC monthly if the family appears to be eligible for it, regardless of whether or not it is actually received. This is not only unfair to those who do not receive it, but also requires states to expend considerable administrative effort judging potential eligibility, estimating the amount of the credit that should be counted, and then at the end of the tax year reconciling this with the amount the family actually receives. In addition, few working families are now likely to qualify for the EITC, since the 1981 reconciliation changes removed so many full-time workers from the rolls. In sum, we believe the inequity and work burden exceed any possible gain from a policy which in effect is nothing more than giving a benefit with one hand and taking it away with the other.

Allow states to waive recoupment of overpayments when it is not cost-effective to purse collection. It is a waste of public funds to require that states go after overpayments to former recipients when the costs to collect will exceed the amount owed.

Give states dicretion in choosing when to make a protective payment. Currently, states must remove the parent from AFDC and make a protective payment on behalf of the children to a third party when the parent fails to cooperate with WIN and workfare requirements, fails to assign child support rights, or otherwise refuses to cooperate with child support enforcement. Broader state authority than this is needed because; (1) it may be incorrect to assume the sanctioned parent cannot properly spend the child's benefit, (2) it is often difficult to identify someone to serve as a protective payee, and (3) use of a protective payment does not in practice restrict the parent's access to the benefit. States should be permitted to decide on a case-by-case basis when to make a protective payment in these circumstances, as they now do in all instances of money mismanagement by the parent or caretaker.

When determining an alien's eligibility and benefits, require that the income of the organization or agency sponsoring the alien be considered. At present, only the income of individuals who sponsor aliens is counted. This technical correction has also been proposed by the administration.

*Enhance responsiveness to need*

Finally, we come to the gaps in the coverage provided by the AFDC program. Constrints in existing law sometimes make the program less responsive than it should be to the needs of poor families. This has been especially evident during the past two years of high unemployment, as states have been often unable through AFDC to help children and their parents in genuine need. To help remedy this situation, we propose the following changes:

Convert the monthly reporting/retrospective budgeting requirement to a state option; and for states that use the option, allow for the payment of federally matched benefit supplements when family income decreases and, owing to the built-in delay in retrospective budgeting, the regular benefit cannot be immediately adjusted to reflect this increased need. There is no convincing evidence that monthly reporting/retrospective budgeting improves the accuracy of eligibility and benefit determination to the point where a nationwide mandate, as is now the case, is sensible. States are in the best position to decide when and where these administrative methods would be effective for their individual AFDC caseload. As for supplements, states may provide them now but entirely at their own expense.

Allow federal funding to cover the need of the incapacitated or unemployed father when aiding pregnant women. Based on a statutory change in 1981, states may only provide aid during the third trimester to a pregnant woman with no other children. The father cannot be covered until the child is born. By contrast, if a woman is pregnant but also has other children receiving aid, both she and the father may be eligible for AFDC. Our recommendation is to do away with the inequity by letting states respond to the actual need that exists.

Remove the restriction that limits the use of AFDC emergency assistance by a family to one unforeseen emergency per year, and reimburse states for their emergency assistance expenditures at the regular AFDC matching rate. The current limit—thirty consecutive days in any 12-month period—makes it difficult for states to respond flexibly to the emergencies families face. And the existing reimbursement rate of 50 percent ignores the serious fiscal difficulties states are experiencing and their different abilities to raise revenue, and may be the main reason why ony half of the states provide emergency assistance under their AFDC programs. Making the changes we suggest would enable AFDC to better respond to crises and would reduce the need in the future for special federal appropriations such as the recently enacted Emergency Jobs and Humanitarian Aid legislation.

Create a standard filing unit in the AFDC program that includes the parent(s) and all minor related children. This change, also proposed by the Reagan administration, would help assure that AFDC benefits reflect a family's true financial circumstances because family members with outside income—such as earnings or child support—could not be removed from the AFDC unit. Under current law, AFDC families can decide which members to include and often do not seek assistance for those with outside income sources. As a result, these resources, which are generally available to the whole family, are not counted when determining AFDC eligibility and benefits. Recipients of supplemental security income should be excluded from the requirement, however, because these family members often have special needs.

The other part of our plan for income maintenance improvements concerns the child support enforcement program, Title IV-D of the Social Security Act. During the past several months, it has heartened those of us responsible for the administration of this program to see the heightened public and congressional interest in child support. We believe getting absent parents to meet their support obligation holds great promise for further reducing the cost to the general public of meeting the income needs of children.

Since enactment of Title IV-D in 1974, the states have made substantial progress in developing a cost-effective child support enforcement system. In fiscal year 1982 states collected more than $1,754 billion in support for children in both AFDC and non-AFDC families, but spend only $591 million on administration. This comes out to a benefit/cost ratio of $2.97 in collections for every dollar expended on the program. In light of this accomplishment, there is little reason to make any radical changes in Title IV-D. Rather, what is needed is a continuing effort to build on the strengths of the program, so that over time a growing proportion of absent parents fulfill their obligation to support their children.

The state administrators' plan for strengthening child support enforcement calls for a dual stragegy. The first part of this strategy entails a series of legislative changes that have been proposed by the administration. The second part is a call for a joint effort by the Congress, the Executive Branch, and the states to explore ways to enhance performance within the child support enforcement system in the long run.

The legislative proposals we have in mind include the following:

Change the annual audit of state IV-D programs to a periodic one and establish a graduated penalty for non-compliance with federal requirements. In lieu of the annual audit and the five percent (of federal AFDC reimbursement) penalty, a triennial audit would be conducted and results-oriented performance standards would be established. In making these changes, the existing period for resolving federal-state audit differences should be retained, so that a state's cash flow is not jeopardized. Also, the assessment of the penalty should be based on both statutory compliance and measures of program effectiveness supported by the states, as well as the federal government. States believe that this will do what is needed to improve state CSE performance, making the administration's refinancing proposal and mandatory state law changes—which the states oppose—unnecessary at this time.

Require the U.S. Postal Service to verify addresses to help locate absent parents and allow states to immediately contact the federal parent locator service. This will increase the sources of location information and enable states to contact the federal parent locator service before going through the costly process of exhausting all local information sources first and will be especially helpful for cases where the parent is known to have moved out of the immediate area.

Permit states to collect child support for children in foster care, so long as they have authority to decide when pursuit of support would not be in the best interests of the child. Authority to pursue support for these children was inadvertently omitted when the Title IV-E foster care program was enacted in 1980.

Extend the Social Security Act's waiver and demonstration authority (Section 1115) to the child support enforcement program. This authority allows states to test innovations that do not have to involve new federal costs. Given the increasing emphasis being placed on it, the Title IV-D program would benefit from a change in the law allowing states to demonstrate more effective or efficient ways to collect support.

Under the second part of our proposal, the states and the federal government would jointly undertake a thorough examination of different ways to enhance the role of child support in the nation's income security system. The chief aim of such an effort would be to accumulate, within a specified timeframe, information on the relative costs and benefits of the different approaches, so that sound judgments could be made about the desirability of making major changes in the current program. The study could include the administration's proposals for financing administration of Title IV-D out of support collections and for requiring states to adopt certain enforcement techniques, Senator Wallop's legislation for a child support tax, and other substantial reform ideas. This would also give Congress an opportunity to scrutinize the current operation of the child support enforcement program, in order to pinpoint the weaknesses that a reform effort would be designed to overcome. All in all, while the state administrators are not adverse to change, we are convinced that any significant shifts in federal child support policy should await the results of a more careful analysis of the options than the current political climate permits.

## HEALTH CARE

I would now like to move to the area of health care and discuss our recommendations for the medicaid and maternal and child health block grant programs.

Like AFDC, Medicaid has been the focus of major cost containment efforts during the past two years. States have had to live within an annually adjusted federal cost ceiling since 1981 and have been granted greater flexibility to design and operate their Medicaid programs in more efficient ways. As a result, the annual growth in Medicaid costs hit 9.9 percent in fiscal year 1982, falling from 15 percent during the five previous years and out-performing Medicare by more than 8 percentage points, and 31 states came under their federal expenditure targets, far exceeding federal expectations.

Given the states' cost containment performance to date, there is no reason to continue the federal cost ceiling—known as the reduction in Medicaid payments policy. States already have a strong incentive to control expenditures, since Medicaid is a much larger part of their budgets than it is of the federal budget, and since nearly every state is barred from running a deficit. Continuation of the limits into fiscal year 1984, when the federal payment reduction reaches four and a half percent, will mean for 17 states an effective matching rate lower than the statutory minimum of 50 percent. The ceiling will no longer serve as an inducement to curb expenditures, but will become instead an outright shift of costs from the federal government as states are forced to spend more of their own funds to maintain essential services. Extension of the policy beyond fiscal year 1984 would put these services in serious jeopardy.

The federal and state interest in Medicaid cost control would be better served by making adjustments in those aspects of the program which have not been adequately addressed by legislation the past two years. We offer the following ideas:

Give states sufficient flexibility in requiring copayments of Medicaid recipients. The current policy is so delimiting that states are choosing not to use copayments. The administrative effort involved exceeds the payoff in terms of reductions in unnecessary utilization of services. The administration's proposal for mandatory copayments is no better, and may be even worse since it leaves states no choice. Copayments can be effective, we believe, but only if states have the authority to decide which services they would apply to, what levels they would be set at, and which groups of recipients would be affected. In this way, states would be able to address their specific utilization problems—problems which vary in nature and degree from state to state. (For a more detailed statement of our views on copayments, please refer to the Council's written testimony submitted for inclusion in the record of the Finance Health Subcommittee's hearings on May 16, 1983.)

Require state child support enforcement agencies to petition courts to include medical support in the child support order whenever health care coverage is available to the absent parent at a reasonable cost. This regulatory change, which has been recommended by the administration, will protect Medicaid as the payor of last resort. States should be permitted to use either Title IV-D or Title XIX funds to pay for this activity.

Require Medicaid applicants to assign their health insurance rights to the state as a condition of eligibility. This proposal by the administration will strengthen the hand of state Medicaid agencies in securing third party reimbursement for services provided under Medicaid.

Shore up federal funding for state's efforts to obtain reimbursement from third party payors. At present, these activities are financed at the normal administrative match of 50 percent. We suggest raising the match to 90 percent for the design and planning of third party recovery systems and 75 percent for operating costs. Studies have shown such systems to be highly cost-effective, but start-up costs are ususally quite high. Currently, antifraud and abuse efforts, which are typically not as effective as third party recovery in recouping funds, receive 90 percent matching for planning, development, and operation in the first year and 75 percent financing thereafter.

Modify the requirement that patients in skilled nursing and intermediate care facilities be recertified by a physician every sixty days. Under current law, recertification must be provided to every Medicaid patient in a facility every sixty days, or funds to the entire facility are disallowed. Facilities generally have no control over physicians' visiting schedules, yet both they and the state may be penalized for a physician's failure to comply. One source has estimated that the requirement costs the federal and state governments more than $100 million a year, without significantly affecting patient care. As a way of saving funds with no loss in the quality of service, we propose that federal law call for substantial, rather than 100 percent, compliance with the recertification requirement.

Allow states to conduct annual inspections and reports by medical review teams of skilled nursing and intermediate care facilities by sampling patient records. The law now stipulates that states must see to it that all patient records are checked during the yearly review, in order to determine the quality of patient care. Use of a sample—a standard audit practice employed thoughout the public and private sectors when dealing with large numbers—would accomplish the same objective at less cost.

While cost containment has dominated the public debate in recent times, it is essential that we not overlook the critical gaps which continue to exist in health care coverage. Although these gaps are not nearly as large as they were two decades ago before the major federal initiatives in health, their very existence today is a sober reminder of what remains to be done to assure that all people have access to adequate health care. At the same time, we must also come to grips with the futility of trying to meet these needs all at once. Given the tremendous pressures on all levels of government to curb spending, we doubt the political will exists right now to raise taxes or shift budget priorities enough to secure the resources necessary. This limitation does not have to mean, however, that all efforts to expand health care coverage must come to a halt or be brushed aside until the return of better times. In a society as wealthy and compassionate as ours, sufficient money and support can always be found to fill the gaps incrementally. In this spirit, we make the following suggestions for improving the health protection of mothers and children. No group, as I'm sure you would agree, is more deserving of public resources.

Let states provide Medicaid coverage to low-income children and their working mothers who have lost AFDC eligibility owing to increased countable earnings. Changes made in the earnings disregards by the reconciliation legislation of two years ago have removed many single-parent families from AFDC, thereby ending their categorical eligibility for Medicaid. State administrators believe that a significant number of these families have no health care coverage per se and, when they need medical attention, are likely to seek it out in expensive hospital emergency rooms. A limited telephone survey of such former recipients in the Research Triangle Institute study mentioned earlier found that more than 44 percent had no health insurance. The current policy of denying Medicaid under this circumstance creates a powerful incentive for mothers to quit or avoid work in order to stay on or become eligible for AFDC and thus secure Medicaid coverage for their children. Allowing states to extend Medicaid to the people in this group may mean the difference between self-support and permanent welfare dependency.

Allow states to provide services under Medicaid to children and pregnant women whose incomes are below 55 percent of the federal poverty line. Many of the people in this group have no health coverage whatsoever. Yet, we have known for a long time that lack of health care at any early age often leads to significant health problems and more costly care later in life, not to mention the adverse effects on the child's educational and social development. Funds have been provided in both the Senate and House budget resolutions to initiate such health protection in fiscal year 1984. As Congress pursues legislation in this area, we urge that consideration be given to allowing states to determine the nature, scope, and duration of services they will cover for children and pregnant women. State flexibility will help to assure the cost-effectiveness of the coverage provided.

Index the maternal and child health block grant to inflation. Although Congress increased funding for the MCH block grant this year, indexation is needed for states to maintain services over time.

In concluding our views on health care, I wish to call the committee's attention to the impact that proposed changes in beneficiary cost-sharing under Medicare will have on Medicaid. The administration recommends restructuring the Medicare hospital insurance (Part A) cost-sharing requirements and increasing the patient premiums and deductibles for the program's supplemental medical insurance (Part B). Since Medicaid now pays these charges for low-income Medicare beneficiaries who qualify for both programs, the administration's proposals will significantly increase Medicaid costs. States are not in a position to absorb these costs without curtailing other essential services.

## SOCIAL SERVICES

The last topic I would like to address in this testimony are the social service programs for which the Finance Committee is responsible, specifically, Titles XX (social service block grant), IV-B (child welfare services), and IV-E (adoption assistance and foster care) of the Social Security Act.

The state administrators have long held that social services are an integral part of the larger human service systems. While income maintenance and health care may be the more visible components of this system, social services help people resolve or cope with problems—ranging from the need for day care to the difficulty a frail older person faces remaining in the community—that if ignored would lead to undesirable consequences for individuals, families, and society as a whole. The federal government has recognized the value of these services by establishing programs such as those carried out under the titles of the Social Security Act. In recent years, federal policy also has tended to reflect a preference for giving states the discretion—within broad national guidelines—to allocate social service resources according to their own priorities and the needs of their citizens. We believe this has been a positive development, and urge that state flexibility be preserved as you consider proposals this year for added funds or changes in social service policy.

While state administrators think the basic federal policy framework for social services is sound, there are two general areas in which congressional attention is needed. The first has to do with the adequacy of existing financial resources. As I noted at the outset of my testimony, many social problems are on the rise, owing in part, although not exclusively, to the recession. Social services are needed in order to deal effectively with a number of these problems. Unfortunately, state treasuries, ravaged by the nation's economic tailspin the past few years, simply do not have the money required to mount the effort. Consequently, we think it is extremely important that Congress give consideration to increasing funds for programs such as Title XX and Title IV-B, through which states can respond appropriately to the need for social services.

The second area concerns changes states would like to see made in Public Law 96-272, the Adoption Assistance and Child Welfare Act of 1980. We worked closely with Congress in developing this legislation and supported its enactment. However, our experience with implementation the past three years has pointed up the need to make some improvements in the law, so that states will be better able to carry out its mandate of securing permanent homes for children. The changes we propose include the following:

Make permanent the authority in Public Law 96-272 that allows states to use Title IV-E funds for children placed voluntarily in foster care. This authority expires at the end of this fiscal year. Although few states have actually requested federal reimbursement under the temporary authority, many have indicated that were the provision permanent, they would likely participate due to the certainty of federal funds.

Remove the prohibition against states spending Title IV-B (child welfare service) funds on adoption assistance payments in excess of the total amount expended for this purpose in fiscal year 1979. This restriction works against the states in finding adoptive placements for children, which we doubt was Congress' intent in enacting the legislation.

Exclude the Title IV-B funds expended directly by Indian tribes when determining whether a state's expenditures for employment related day care, and adoption assistance under Title IV-B exceed the amount spend for these purposes in fiscal year 1979. The law bars states from spending above the fiscal year 1979 level for these services. States, however, should not be penalized for expenditures by Indian tribes over which they exercise no control.

Repeal the requirement that states redetermine a childs' eligibility for Title IV-E foster care every six months. The redetermination requirement is a carryover from Title IV-A, the program under which foster care was financed until enactment of Title IV-E as part of Public Law 96-272. Redeterminations are a costly exercise in foster care, rarely producing a finding of ineligibility. Eliminating the provision would save federal money without a diminution in the integrity of Title IV-E.

Allow continuation of Medicaid during the period after a child is placed for adoption and before the adoption is finalized and the Title IV-E adoption subsidy begins. Currently, a child who has been removed from foster care and for whom an adoption petition has been filed, does not qualify for Medicaid until an interlocutory decree is ordered or the final decree is issued, thus triggering the adoption assistance payment. In other words, the Medicaid coverage the child received while in foster care lapses until adoption assistance begins. Some states are having to license pre-adoptive homes as foster care facilities, and pay the family the foster care, which is often higher than the adoption assistance payments, in order to preserve Medicaid coverage.

In this testimony, I have outlined a plan for making the AFDC, child support enforcement, Medicaid, and social service programs work better. Our approach is not doctrinaire but pargmatic, aimed as it is at striking an appropriate balance among the main objectives of social policy-adequacy, fairness, and efficiency. The nation's welfare administrators believe the proposals I have sketched here mesh well with the fiscal stringency and political caution of the times while preserving our society's public commitment to a sound public welfare system. We hope you share this view.

Attached as an appendix is a list of my organization's positions on the administration's fiscal year 1984 budget proposals for welfare programs.

That concludes my statement, Mr. Chairman. We look forward to being of further assistance as you and your colleagues face the difficult choices of setting policy for the year ahead.

## APPENDIX.—POSITIONS ON THE ADMINISTRATION'S PROPOSAL

### AID TO FAMILIES WITH DEPENDENT CHILDREN

Reaffirm opposition to mandatory shelter and utilities proration for families living in larger households. Shelter and utilities proration is both error prone and contrary to the flat grant concept.

Reaffirm opposition to excluding the needs and income of the caretaker relative when the youngest child is 16.—These parents often have been out of the active labor force for all or most of their child-rearing years and continue to need assistance in making the transition to paid employment. State welfare agencies are also concerned about the potential this proposal has for encouraging teenagers to leave school and the cost shift to states that would occur.

Reaffirm opposition to mandatory community work experience programs (CWEP) and job search for AFDC applicants and recipients.—These should remain state options. States however, should have the option to require parents with children under the age of 6 to participate in work activities if day care is available and there is funding for AFDC work programs.

Oppose the proposal to eliminate absence from the home solely by reason of employment as an AFDC deprivation factor.—As proposed, this would have no practical effect on AFDC recipients in that it is essentially unenforceable. It is not clear why the administration is recommending this change and what it expects to achieve.

Support creation of a standard AFDC filing unit that includes the parent(s) in the home and all minor related children. Recipients of supplemental security income (SSI) would be exempt.—This would help assure that grants reflect a family's true financial circumstances.

As an alternative to the existing policy and the administration's fiscal year 1984 proposed change, support using the food stamp striker's policy in which aid continues at the pre-strike level for AFDC. This would make the policies of the two programs consistent and would remove AFDC from a role in determining strike behavior.

Reaffirm opposition to expanding access to AFDC information. The existing regulations allow sufficient access to information and include the necessary recipient protections.

Reaffirm support for the application of the alien sponsor provision to organizations and agencies. Currently, only the income of individuals who sponsor aliens is counted when determining AFDC eligibility and benefits.

Support the proposal to allow states to penalize persons who voluntarily quit or reduce employment. This would expand current law by applying the voluntary quit provision to persons who are exempt from WIN because they are working for more than 30 hours per week or are remote from a WIN site.

Support the proposal to allow states to require parents with children age 3-6 to participate in WIN if child care and federal WIN funds are available. To avoid long term AFDC dependency, it is important that parents become involved in work as early as possible without jeopardizing the child's care.

## CHILD SUPPORT ENFORCEMENT

Reaffirm opposition to financial restructuring of the administrative costs in child support enforcement (CSE). This proposal does not adequately address AFDC cost avoidance and the costs of paternity establishment, could adversely affect state budgeting cycles, and provides no incentive for interstate collections. The audit changes proposed by the administration will do what is needed to improve state performance. State agencies, however, remain willing to work with Congress and the administration on improving CSE financing and performance.

Support improving the effectiveness of child support enforcement programs by encouraging states to adopt more effective techniques such as: wage withholding when a delinquency equivalent to 2 months' support occurs; quasi-judicial procedures for the establishment and enforcement of support orders; a state income tax intercept system, in states with an income tax and a taxpayer refund possibility; and liens against property. States should decide which of these techniques may be most effective, given states' individual circumstances.

Reaffirm support for changing the annual audit to a periodic one and graduating the penalty for non-compliance. In lieu of the annual audit and 5 percent (of the federal AFDC reimbursement) penalty, a triennial audit would be conducted and results-oriented performance standards established. In making this change, the existing period for resolving federal-state audit differences should be retained and the assessment should be based on both statutory compliance and measures of program effectiveness that are supported by both the federal and state governments.

Reaffirm support for requiring the U.S. Postal Service to verify addresses for location purposes and allow states to use the federal parent locator service as needed. This will increase the sources of location information and enable states to contact the federal locator service before exhausting all local information sources, which is especially helpful for cases where the parent is known to have moved out of the immediate area.

Reaffirm support for child support collection for certain children in foster care so long as states are allowed discretion for instances when pursuit of child support would not be in the best interests of the child. Authority to pursue support for these children was inadvertently dropped under the new IV-E foster care program.

Reaffirm support for extending the section 1115 waiver authority to the child support enforcement program. Innovative program ideas (which do not involve a federal cost) can be tested with this waiver authority.

Support the HHS proposal for modifying the timing and content of the annual report to Congress on child support enforcement. To give HHS more time to receive and analyze state's fourth quarter data, the annual report to Congress would be delayed by 3 months, making it available 6 months after the close of the fiscal year. Two reporting changes would also be made: states would no longer be required to report spousal support cases separately, and states would be required to report interstate cases.

Support requiring that CSE agencies petition the court to include medical support as part of the child support order whenever health care coverage is available to the absent parent at a reasonable cost. (Same position under Medicaid section.) This will reaffirm that Medicaid is the payor of last resort. States should be able to use either IV-D or Title XIX funds to support this activity.

### MEDICAID

Oppose the implementation of mandatory copayments on certain services for Medicaid recipients. Copayments are a worthwhile policy to pursue, but states should be given the flexibility to decide which services copayments would be applied to, at what level they would be set, and which groups of recipients would be affected by them. This flexibility will allow states to address their specific utilization problems, which vary in nature and degree from state to state.

Support requiring state child support enforcement agencies to petition courts to include medical support as part of the child support order whenever health care coverage is available to the absent parent at a reasonable cost. (Same position in Child Support Enforcement section.) This would help states in their third party recovery efforts.

Support requiring Medicaid applicants to assign their health insurance rights to the state Medicaid agency as a condition of eligibility. This is another way to help states in their third party recovery efforts.

Oppose the complete elimination of peer review organizations (PROs) and hospital utilization review. States should be given the option to continue hospital utilization review with federal financial support, and hospitals should be required to continue monitoring their own utilization levels. Some utilization review is necessary to control program costs.

Modify the sixty-day certification requirement for patients receiving skilled nursing facility and intermediate care facility services. Rather than requiring that every patient in a facility be recertified every 60 days, federal law should call for substantial compliance. Currently, 100 percent compliance is required or funds to the entire facility are disallowed. The facility usually has no control over a physician's visiting schedule, yet can suffer because of it.

Allow states to conduct required inspections and reports by medical review teams of skilled nursing facilities and intermediate care facilities on a periodic basis using sampling techniques. Currently, states must check all patient records annually, when a sample could accomplish the same objective of monitoring the quality of patient care.

Support allowing Medicare intermediaries to process claims for services reimbursable under both Medicare and Medicaid with the federal government paying 100 percent of the administrative costs, so long as the state is given the option to do this, its own Medicaid rates are used for payments, and the data obtained through Medicare are provided to the state Medicaid agency. These changes will reduce the administrative work necessary when claims for both programs have to be processed.

Strongly oppose any continuation of the reduction in payment policy beyond fiscal year 1984. This is an arbitrary method of shifting program costs from the federal government to state and local jurisdictions.

Funding for health care block grants should be properly indexed for inflation. These grants received reduced funding in fiscal year 1982, and have been frozen at that level in fiscal year 1983. Four states to maintain services, indexation of the block grants is needed.

## STATEMENT OF JAMES M. HACKING, ESQ., ASSISTANT LEGISLATIVE COUNSEL, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, D.C., ACCOMPANIED BY MARTIN CORRY, LEGISLATIVE REPRESENTATIVE, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. HACKING. Thank you, Senator. On my left and accompanying me is Marty Corry, who is one of AARP's legislative representatives.

Senator CHAFEE. We know him well.

Mr. HACKING. The Association's statement that I would like to submit for the record contains sections that are not directly related to the subject matter of this hearing, but are related to the subject matter of the committee's planned future hearings. We would like to have all our views on the record and, therefore, I am taking this opportunity to submit them all at once.

Given the time constraint, I wish to concentrate my remarks on the medicare program and on the administration's proposals in that regard.

First, let me give you some idea of the attitude with which AARP approaches this committee's important series of hearings. We have been very active this year in the budget process, more active in fact than in any preceding year. The reason for that is that AARP is alarmed at the size of the currently forecast deficits and by the fact that they are expected to grow over time. The currently forecast deficits of $200 billion and more, if allowed to materialize, are almost certain to cause interest rates to rise if monetary policy is not accommodating, and that would likely choke off the recovery and bring on a new recession. On the other hand, if monetary policy is accommodating and interest rates are kept down, we will likely see a very strong resurgence of inflation which will do serious damage to the elderly and to the economy. Moreover, deficits of the magnitude currently being forecast will create great pressure—perhaps irresistable pressure—to dismantle the entitlement programs on which the elderly have been forced to depend for income support and health care protection. Therefore, in AARP's view, we must have a budget and a budget resolution that addresses in a sensible manner the structural portion of the forecast deficits. That is going to require holding down increases in spending for defense and raising revenue, a lot of revenue. But that is not enough. Once we have a sensible budget resolution, it has to be adhered to.

Realistically, we expect that a long list of domestic spending programs will be targeted for expenditure reductions and medicare, just because of its very size, is likely to be included in that list.

With respect to medicare then, let me say, first, that AARP has and will continue to oppose proposals that merely shift costs away from the medicare program on to program beneficiaries. We, therefore, are opposed to the administration's proposal to introduce coinsurance under part A for the 2d through 60th day of a hospital stay; the indexing of the part B deductible to the medicare economic index; and the increase in the part B premium over the period 1984 through 1988 to cover 35 percent of the part B program's cost. We also oppose the proposed 1-year freeze of physician fee screens because, standing alone, it is likely to result in just increased out-of-pocket cost to beneficiaries with no effect on aggregate physician income.

We reject the argument that the elderly are overly insulated from the cost of health care services, and that increasing their out-of-pocket cost will hold down the rate of health care cost escalation.

Medicare's rapid cost escalation is not going to be solved by shifting costs to beneficiaries. That will have no effect on the way hospitals and physicians behave, at least not until vast numbers of elderly persons are unable to afford to enter a hospital or see a physician. Congress should address the root causes of medicare and medicaid's cost escalation problem and take action that will be immediately effective in drastically reducing the rate of increase in health care cost, in general, and hospital cost, in particular. We believe that in the short term that will require an across-the-board cap on the rate of increase in hospital costs and revenues. The TEFRA limits are inadequate, and the prospective payments scheme is too little, too weak, and too late to prevent medicare's impending insolvency or make any substantial contribution in the near term to the effort that is needed to reduce dramatically the rate of increase in health care cost.

If we are going to allocate automatically an ever increasing amount of resources to hospitals, we will never have the resources necessary to promote less costly alternatives to in-patient hospital care or to begin to put into place the kind of integrated long-term care program that is going to be needed over time to accommodate an ever increasing elderly population.

That concludes my remarks, Mr. Chairman. I thank you for having had this opportunity to present them.

Senator CHAFEE. Thank you very much, Mr. Hacking. And now, Mr. Hutton.

[The prepared written statement of Mr. Hacking follows:]

## STATEMENT OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS

Thank you, Mr. Chairman, for allowing us to present our views regarding the Administration's spending reduction proposals for the Medicare and Medicaid programs. We would also like to take this opportunity to discuss briefly tax expenditures and the Administration's proposal to cap the exclusion of employer-provided medical care.

### MEDICARE

The Administration's proposals to reduce spending in Medicare are based on the notion that the elderly are not health cost conscious—that they are somehow insulated by Medicare from the "true" cost of health care. Because of this insulation, so the theory goes, the elderly misuse or overuse the system and thereby increase Medicare costs. AARP rejects that theory.

The elderly are the most cost conscious health care consumers in this country. They have to be. Although they represent less than 12 percent of the population, the elderly account for 31 percent of all expenditures for hospital services, 28 percent of expenditures for physician services, 24 percent of prescription drug expenditures and 80 percent of all nursing home expenditures. Since Medicare pays for less than half of the elderly's health care expenses, the elderly are painfully aware of the cost of paying for their own health care needs out of pocket. Moreover, AARP is not aware of any evidence to indicate that the elderly abuse or misuse the system. The escalating cost of Medicare is a function of uncontrolled health sector inflation, particularly hospital cost inflation, not beneficiary use of the system. Measured against the elderly's limited, fixed income and their huge out-of-pocket expenditures for health care, the Administration's proposals for greater beneficiary cost sharing can only be characterized as punitive.

The Administration's budget requests $59.85 billion in Medicare outlays in fiscal year 1984, assuming legislated savings of approximately $2 billion from current policy. (This is in addition to approximately $5.1 billion in fiscal year 1984 cuts already on the books). These proposed cuts in Medicare increase to $4.3 billion by 1988. In addition, increases in Medicare premiums beneficiaries are required to pay will total $4.5 billion by 1988. Thus, by 1988, total program reductions and premium increases resulting just from the Administration's fiscal 1984 budget request will total $8.8 billion. Approximately 90 percent of the reductions will result in increased copayments, premiums and deductions to be paid directly by Medicare beneficiaries.

Before describing the impact of the Administration's proposals to reduce Medicare expenditures, a perspective on the scope of beneficiary out-of-pocket costs is in order.

*Beneficiary out-of-pocket costs*

Personal liability for the cost of health care provided to the elderly derives from a number of sources, all of which have been subject to significant increases over the past several years. The elderly pay directly for the following:

1. *Deductibles under parts A & B.*—The Part A deductible has increased from $104.00 in 1976 to $304.00 in 1983, an increase of 192 percent over the past 7 years. The annual Part B deductible has increased from $60.00 in 1980 to $75.00 in 1983 (an increase of 25 percent).

2. *Co-insurance (part B).*—Actual per capita coinsurance charges borne personally by the elderly increased by 345 percent between 1972 and 1982.

3. *Cost-sharing (part A).*—In 1981, out-of-pocket payments for both the inpatient deductible and coinsurance liability constituted over 14 percent ($5.3 billion) of all hospital expenditures, a 23 percent increase in out-of-pocket payments since 1977.

4. *Charge reductions on unassigned claims.*—(For example, the difference between the Medicare "allowed" charge and the actual charge be the physician for which the beneficiary is personally liable):

Between 1977 and 1982, the total dollar amount of "charge reductions" passed on to elderly Medicare beneficiaries jumped from $674,000,000 to $2,006,000,000 (an increase of 198 percent over a five-year period).

Approximately 48 percent of all Part B claims submitted to Medicare for reimbursement at this time are "unassigned", compared to an over-50 percent non-assignment rate in 1977. Nevertheless, beneficiary liability for "unassigned" claims has increased dramatically over the past five years even though the number of claims paid on assignment has increased during the same period.

5. Aged Medicare beneficiairies are personally liable for a signicant number of critical non-covered services and products—including dental services, dentures, prescription drugs, eye glasses, hearing aids, etc.—for which they paid $7.1 billion out-of-pocket in 1981, a 60 percent increase in their out-of-pocket liability for such products and services since 1978.

6. *Coinsurance for skilled nursing home care and charges for all ICF care.*—Approximately half of all nursing home expenditures made on behalf of the aged were financed directly by out-of-pocket payments in 1981. As HCFA researchers have noted: "Even if other sources comprised half of the total payments, the average out-of-pocket expenditure for private-paying patients would still be over $100 per week."

7. *SMI (part B) premiums.*—Out-of-pocket premium payments by the elderly for Medicare Part B coverge totalled $78 annually in 1977 as compared with a current annual figure of $146, an 88 percent increase in SMI premium payments by the elderly over the past five years.

8. *Private health insurance premiums.*—Approximately 65 percent of aged Medicare beneficiaries are sufficiently concerned about the gaps in Medicare coverage to purchase private health insurance policies designed to supplement medical expenses. Currently, low option private insurance plans cost aged Medicare beneficiaries approximately $230 per year, while high option plans cost roughly $600 per year. These figures compare with an annual private insurance premium rate of $90 just five years ago.

Finally, there is evidence to suggest that fewer and fewer of the elderly are financially able to retain such supplemental policies once they are purchased. Blue Cross/Blue Shield of Florida has recently pointed out that the "persistency rate" (i.e., the percentage of those aged beneficiaries who had coverage at the beginning of the year and continue to have coverage at the end of the year) has dropped from 93.3 percent in 1978 to 86.9 percent in 1982.

Persons aged 65 and over paid roughly $700 out-of-pocket per capita for medical expenses in 1977. By 1981, this amount had increased by 71 percent of $1,200 per capita, equalling 14 percent of the annual per capita income of the aged ($8,638). The Administration's proposals to increase beneficiary cost sharing impact most directly those aged beneficiaries least able to bear the burden: they do nothing to address the forces driving health sector inflation—uncontrolled growth in health care costs.

### THE ADMINISTRATION'S PROPOSALS TO REDUCE MEDICARE EXPENDITURES

*Require part A users to pay, in addition to the deductible, 8 percent of the deductible ($28) for the 2nd thru 15th day of hospitalization and 5 percent ($17.50) for the 16th thru 60th day of hospitalization for any spell of illness with catastrophic protection for part A services only after the 60th day*

For an average Medicare hospital stay of eleven days, beneficiaries will pay an additional $280 (plus a $46 increase in Part A deductible, effective January 1, 1984), equalling a 107 percent increase in the average Part A user's out-of-pocket costs for hospitalization.

The Administration is "selling" this proposal as a good deal for beneficiaries because of the catastrophic stop-loss protection. But the catastrophic protection is a pretense. Only 0.6 percent of enrollees and only 2 percent of Part A users ever go beyond 60 days of hospitalization. The irony inherent in the Administration's proposed catastrophic trade-off is that less than one percent of Medicare beneficiaries ever experience the kind of catastrophic illness capable of triggering the catastrophic protection; however, each beneficiary who does enter the 61st day of hospitalization will have already paid $1,529 out-of-pocket compared with $304 under current law. Moreover, such stop-loss protection means little to Medicare beneficiaries because it applies only to inpatient hospital services. It ignores the huge out-of-pocket costs for physician services associated with long hospital stays and the major source of catastrophic health care costs for the aged—long term (nursing home) care.

*Index the part B deductible to the medicare economic index (MEI)*

The MEI is the index developed by HCFA to update the physician fee screen under Medicare. The Administration proposes to adjust the Part B deductible annually according to the increase in the MEI. HCFA estimates that the MEI will crease 6.4 percent in 1984. If this projection is correct, the cost of the Part B deductible would rise from $75.00 per year to approximately $80 per year.

The MEI has risen an average of 8 percent per year since the index began in 1976. Had the Part B deductible been indexed to the MEI in 1976, ($60 in 1976) the current deductible would be approximately $100 per year instead of $75; a 25 percent increase.

*Delay establishing part B premium at 25 percent of program cost until January 1984, then incrementally increasing premium to 35 percent of program cost by 1988*

Enactment of this proposal will result in an increase in the Part B premium from its current level of $146.46 per year to $399.60 per year by 1988. HCFA projects the Part B premium to increase to $228.00 per year in 1988 under current law. Hence, this proposal is estimated to increase beneficiaries' out-of-pocket costs for Part B coverage by 75 percent over current law by 1988.

*Freeze physician reimbursements for 1 year*

While some may regard this proposal as a cut in provider reimbursements, AARP believes it will instead increase beneficiary out-of-pocket costs. Under the proposal, physician fee screens, i.e., reasonable, customary and prevailing charges, would not be updated in fiscal 1984 as usual. The update in 1985 would only cover the period 1984-1985. The physicians would totally lose one year of inflation protection. The effect of this proposal will be to:

(a) increase Medicare beneficiaries' out-of-pocket costs for health care.

Under existing law, Medicare beneficiaries have substantial responsibility for the cost of physician services. Beneficiaries must pay the annual Part B deductible of $75, plus 20 percent coinsurance on all reasonable, customary and prevailing physicians' charges. Between 1972-1982, incurred deductible charges increased by approximately 345 percent. Moreover, beneficiaries are liable for all charge reductions associated with unassigned physicians' bills. In 1980, aged beneficiary liability resulting from unassigned claims exceeded $1.3 billion, an amount representing 13 percent of total physicians' charges for the elderly for that year.

Beneficiary liability for physicians' services results, of course, not only from unassigned claims, but also from deductible and coinsurance charges. These three charge components—charge reductions associated with unassigned claims, deductible, and coinsurance—together represent "variable beneficiary liability" for physicians' services. In 1980, such variable liability for the aged amounted to nearly 35 percent of total physicians' charges due. Further, if Part B premium payments representing a form of "fixed beneficary liability" are combined with "variable beneficiary liability" for 1980, the net Medicare contribution against total physicians' charges falls to only 45 percent, the aged beneficiary being responsibile for the remaining 55 percent of charges due the physician. It is estimated that total beneficiary liability for physicians' charges due under Medicare will increase to over 60 percent in 1983. (See Attachment A).

(b) erode the number of physicians willing to accept assignment.

Currently, approximately 52 percent of all claims submitted to Medicare are submitted by physicians on "assignment" claims, i.e., the physician is willing to accept Medicare's allowable charge as payment in full. A freeze on Medicare physician reimbursements will have a serious negative impact on the rate of assignment, resulting in greater out-of-pocket costs to the elderly. In 1971 President Nixon froze wages and prices under the Economic Stabilization Act (ESA). Between August 1971 and April 1974, while the ESA was in force, the physician assignment rate, i.e., the percentage of claims submitted by physicians for "assignment reimbursement", fell more than 11 percent. (See Attachment B.) And despite the freeze, physician fees rose 16 percent during the same period. (See Attachment C.)

(c) Increase hospital costs: For most of its effective life the ESA restricted increases in hospital costs per admission and in physicians' charges per procedure but did not restrict increases in hospital admissions or in total physician services. Since ESA had no effective limitation on the volume of services, the data indicate that hospitals and physicians responded to the ESA by allowing hospital admission rates to increase. If the Administration's proposal to freeze physician reimbursements becomes law, it is likely that both hospital admissions and total physician services will increase, resulting in even higher government expenditures for health care.

## THE RAND CORP. STUDY

With all due respect to Mr. Newhouse and his colleagues at the Rand Corporation, we are somewhat puzzled by the continual reference to his cost sharing study in the context of Medicare. Mr. Newhouse is the first to point out that the elderly were not included in the sample of the study. Any conclusions about the applicability of the study to the Medicare population must, therefore, be regarded as mere speculation. Moreover, since the cost sharing liability for participants in the Rand Study was limited based on income, it is inappropriate to assume the same kind of results in a non means-tested program.

The Administration and others who believe that the elderly are insulated from the "true" cost of health care point to Medigap insurance as the main insulator. They believe that those having Medicap insurance are encouraged to use health care services more than the uninsured elderly. That theory has been investigated under a HCFA research grant and found not to be a correct description of the effect of private supplementary insurance on the majority of Medicare beneficiaries utilization of health care services. ("Cost Sharing, Supplementary Insurance, and Health Services Utilization Among the Medicare Elderly", Link, Long and Settle, Health Care Finance Review, Fall 1980). Simply stated, the investigators found that "among those elderly beneficiaries with one or more chronic health care problems (about 78 percent of the beneficiary population), persons with some type of supplementation have only slightly more physician visits than those with no additional coverage." (Health Care Finance Review, Fall 1980, at page 28). Thus, for over three quarters of the elderly Medicare population supplemental insurance does not significantly influence their utilization of health care services. Hence, it is unfair and incorrect to characterize elderly Medicare beneficiaries as "insulated" from the cost of health care.

## MEDICAID

In addition to $1.45 billion in Medicaid cuts already on the books for fiscal year 1984, the Administration is seeking further Medicaid cuts of $293 million in fiscal year 1984, for a total of almost $1.75 billion in Medicaid cuts in fiscal year 1984.

Clearly such cuts will further restrict the poor, elderly and disabled from essential medical care.

AARP firmly opposes the Administration's proposal to require states to impose copayments for all Medicaid services except nursing home care. Research sponsored by the Health Care Financing Administration (HCFA) clearly shows that the poor and near poor experience high levels of out-of-pocket costs for health care. "Out-of-pocket costs for the poor and near poor are as high or higher than for higher income groups. Almost all persons in families with out-of-pocket expenses greater than 15 percent of family income had family incomes below 200 percent of the official poverty level." (See Out-of-Pocket Health Expenses for Medicaid and Other Poor and Near Poor Persons in 1980, Howell, Corder & Dobson, January 1983.) It is a cruel hoax for the Administration to seek budget savings from this vulnerable segment of the population.

AARP also opposes the Administration's proposal to permanently reduce federal matching payments to states by 3 percent beginning in 1985. The states have already drastically cut Medicaid eligibility and services to meet the steep cuts in federal matching funds for Medicaid enacted under the Omnibus Reconcilation Act of 1981 (3 percent in fiscal year 1982, 3.5 percent in fiscal year 1983 and 4.5 percent in fiscal year 1984). Again targeting the most vulnerable in society, including nursing home patients, for such an unustified, irrational cut is not only unfair, but poor public policy.

Finally, the Association strongly opposes the Administration's 17 percent reduction in funds supporting state survey and certification of nursing homes. According to the Administration's own projection, the funds budgeted will only pay for surveying less than 80 percent of Medicaid facilities in 1984. This budget proposal challenges the moratorium Congress placed on the Administration's regulations relaxing the survey and certification of nursing homes. What the Administration has been unable to achieve by regulation, they are attempting to achieve through the budget. The Administration's arguments in support of reducing survey and certification were wrong last year when Congress placed the moratorium and they are wrong now. Congress must not allow the Administration to ignore the substantive objections resulting in the Congressional moratorium on survey and certification regulations without correcting the deficiencies that inspired the moratorium in the first place.

## OTHER ALTERNATIVES TO ALLEVIATE THE PRESSURE FOR CUTS IN MEDICARE AND THAT ADDRESS THE UNDERLYING CAUSES OF HEALTH CARE INFLATION

AARP believes that changes in the Medicare program must look beyond immediate budget savings and address the serious long term health cost issues in this country. The federal government, as a major purchaser of health care services, cannot shrink from its responsibility to abate explosive inflation in the health care sector. Since approximately 75 percent of all Medicare expenditures are for hospital costs, the federal government has the market power and the financial interest to abate hospital cost inflation.

The Association has long urged the Congress to place federal limits on increases on hospital costs and revenues. Such an across-the-board approach would not single out Medicare or Medicaid beneficiaries for special restrictions. Time and again, experience has demonstrated that Medicare-Medicaid specific approaches to hospital cost containment merely lead to cost shifting to private paying patients and other third party payers and thus, no reduction in the rate of increase in total hospital costs.

If Congress rejects uniform, across-the-board limitations on increasing hospital costs, then alernatively, the Association recommends that Congress actively encourage the states to adopt mandatory hospital rate review programs. Such programs, in the six states that have them, have shown promise in reducing both public and private sector outlays for hospital care. We urge Congress to provide financial incentives for states to initiate effective hospital rate review programs which can produce substantial savings to both government and private purchasers of hospital care services. Had all states held their increases in hospital costs to that experienced by the six states with mandatory rate review, hospital expenditures nationwide would have been $12 billion less in 1981. AARP believes such state hospital rate review programs have demonstrated their ability to reduce health care costs.

## SUPPLEMENTAL SECURITY INCOME (SSI) DISABILITY ISSUES

The Reagan Administration recently proposed modification in the Social Security and Supplemental Security Income disability programs. These proposals attempt to liberalize a program that is riddled with administrative problems. Unfair and inadequate disability determination standards have led to the termination over the past two years of some 340,000 individuals from the rolls. Congress is well aware of the tragic consequences that have occurred as a result of the way the program is being administered. AARP urges it to act on the urgent need to correct the inequitable procedures in order to prevent further human suffering and hardship.

AARP supports proposals that would expand the definition of "permanent disability" to include more medical and psychiatric conditions, and require a finding of medical improvement prior to the termination of benefits, or the adoption of a more flexibile standard for determining whether a person's impairment is severe enough to render them disabled, thus qualifying them for benefits.

However, these changes which are part of the Administration's package, will prove to be inadequate if done solely through administrative procedures. These proposals do little more than reinforce what the federal courts and Congress have already mandated in the disability determination review process. Administrative policy can often prove to be temporary at best, and what the disability program needs is substantive reform that will have long-term effects. If implemented legislatively, these changes will assure that individuals will have their impairments evaluated under comprehensive and adequate standards.

AARP therefore urges this committee to support legislation such as that introduced by Senator John Heinz and Representative Silvio Conte that calls for a temporary moratorium on all mentally impaired disability reviews until adequate procedures can be developed and implemented.

The General Accounting Office (GAO) recently reported on its investigation of the OASDI and SSI Disability Program at the request of Senator Heinz. The GAO found numerous inadequacies in disability determinations applied to mental impairments. GAO states that:

"(1) An overly restrictive interpretation of the criteria to meet SSA's medical listings, resulting principally from narrow assessments of indivuduals' daily activities;

"(2) inadequate development and consideration of a person's residual functional capacity and vocational characteristics;

"(3) inadequate development and use of existing medical evidence, resulting in an over-reliance and misuse of consultative examinations; and

"(4) insufficient phychiatric resources in most state disability determination sections."

It is imperative that improper procedures such as those indicated in the report are discontinued and that evaluation of the mentally impaired be done in a fair and nondiscriminatory manner. We can no longer permit unwarranted terminations that have caused irreparable (and sometimes fatal) injury to thousands of individuals.

In addition, there is still the need for comprehensive changes in the disability program. Many of the laudable provisions contained in P.L. 97-455 provide only temporary relief and must be made a permanent part of the program. Procedures such as the extension of disability benefits and Medicare coverage through the administrative law judge (ALJ) hearing are necessary in order to allow the disabled to meet their basic needs of food, shelter, and medical expenses and must be continued. It should be noted that the Administration has proposed a retrenchment in existing law by proposing that benefits continue only through the first level of appeal rather than through ALJ level.

AARP hopes that Congress will make a maximum effort to correct some of the procedures which result in denying benefits to individuals who are truly disabled. We would like to see a responsible approach taken to eliminate these inequitable standards and look forward to working with Congress to effectuate comprehensive reform.

## TAX EXPENDITURES AND THE NEED TO RAISE REVENUES

It has been apparent for some time that the "out-year" federal budget deficits are mostly structural, that is, they will not be eliminated even when the economy has returned to higher levels of activity and lower levels of unemployment assuming it is in fact able to sustain a recovery. The root causes of these deficits, in the sense of new actions taken, are the excessively large ERTA tax cuts and increases in defense expenditures, not the growth of income maintenance and "social" programs, which in real terms have barely held their own or have declined.

Identifying those causes leads to the conclusion that revenues must be increased substantialy not only to eliminate the deficits caused by ERTA but also to provide noninflationary financing for the increased defense expenditures which Congress seems likely to approve. The maxim "there is no free lunch" is just as true now as it ever was. The nations could not even then and certainly cannot afford revenue cuts of the size produced by ERTA. Revenues as currently projected are simply not adequate to pay for necessary expenditures. Realistically, nondefense expenditures are not going to be reduced much more, and AARP opposes many of the cuts already made.

We do not subscribe to the rationalization that massive budget deficits are unimportant. The fear of those out-year deficits and their effect on capital and credit markets are some of the principal factors that are currently producing the high real interest rates that, in turn, threaten to abort the recovery.

Another, less overt, reason for giving priority to reducing deficits is that this policy would also help prevent a possible reversion by the Federal Reserve to a more restrictive monetary policy that would put the brakes on the recovery as an antiinflationary policy. We cannot afford such a slide backward to even higher unemployment levels and renewed depression in the durable goods sectors of the economy and the communities dependent on them.

These are the principal reasons why the Association supported TEFRA (even though it contained some individual provisions with which we did not agree) and now advocates further revenue-raising measures. Given the size of the deficits projected, the revenue increases will have to be very large, even larger than TEFRA. Also, given these deficits, it seems not to be an appropriate time to consider changing the basis of the federal tax system. Discussions and arguments over what kind of alternative system to establish would take too long. Revenue-raising actions, timed mostly to take effect in the "out" years, are necessary now.

## THE NEED TO RESTORE THE TAX BASE

The principal ingredient of an effective revenue-raising program should be a phase-out of certain tax expenditures in order to broaden the personal and corporate income tax base. These tax expenditures—"loopholes" to laymen—have been growing at a rate of 14 percent a year, as compared with an 11 percent rate of growth in direct expenditures. ERTA added eleven new categories and expanded twenty-one items already on the books, and although TEFRA in turn reduced some of these, there is no hope of avoiding increases in tax rates, unless the size of the tax base, on which the rates are levied, is increased.

The Congressional Budget Office, in its "Reducing the Deficits: Spending and Revenue Options," lists 29 of what it calls "Income tax base-broadening options." (Appendix A) These options together are projected to save $292 billion over the five-year period 1984–1988.

For example, according to the CBO, a repeal of certain oil and gas industry tax expenditures could raise $6.2 billion in 1985.

$1.7 billion can be gained by repeal of the percentage depletion allowance which is a write-off of 16 percent (in 1983) of the gross income (up to a limit) from select oil and gas wells. This method often allows the well owner to recover much more than the cost of extraction.

$4.5 billion can be raised by repeal of the expensing provision for intangible oil and gas drilling costs. This would allow certain oil and gas drilling costs to be written off in the year they occurred rather than adopting the general approach of depreciating these costs over a period of years.

Given the major restructuring of the corporate income tax that was a part of the Economic Recovery Tax Act of 1981 and increases in energy prices, these incentives to produce may no longer be necessary.

The deductibility of consumer interest payments will cost $10.5 billion in fiscal year 1984 according to OMB. This tax expenditure discourages saving and investment and is available only to persons who itemize their deductions in computing their income tax liability. In the near term, recognition should be given to the need to promote consumption during the recession. However, this expenditure could be modified or phased out in the future.

Current interest in simplification of the tax code may be another avenue to increased revenues, through elimination of certain tax expenditures. However, while simplification of the tax code is a desirable objective, the elimination of the progressive tax rate structure, which proponents of the flat rate tax espose, is not. Such a change would violate the longstanding and sound principle that federal income tax liability should be based on "ability-to-pay."

### *Changes in corporate tax rules*

ERTA made major changes in corporate tax depreciation rules. These changes were in turn modified by TEFRA. While the accelerated depreciation system was considered appropriate for a high-inflation era, current circumstances dictate another look at those rules. Lower inflation may result in useless giveaways under the incentives currently in place.

*Delaying or repealing of indexing*

Beginning in 1985, the income tax brackets, the zero bracket amount, and the personal exemption are due to be indexed. If indexing is to become a permanent part of the tax code, it must not be put into effect until it is affordable. Currently, the existence of the indexing provision in the tax law signals an unwillingness to resolve the long-term deficit problem. Indexing is estimated to cost $6 billion in 1985, with the cost accelerating to $40 billion in 1988. This provison was not part of the President's original 1981 tax proposal, and while not without merit, it should at least be delayed until federal deficits are under control.

*Curtailing personal tax rate reductions*

If other revenue raising measures are insufficient, some of the personal tax rate reduction in ERTA should be scaled back. This could be achieved through a surcharge on federal income tax, which if levied at five percent would yield approximately $15 billion in fiscal year 1984. Alternatively, the July ten percent cut could be postponed, saving $30 billion in 1984. However, given the need for some stimulus to help lift the economy, and the effect of increased payroll taxes, the July 1983 cut could be limited. CBO estimates that capping the July 1983 tax cut at $700 would yield $6 billion in 1984 and $9 billion in 1985, and $37 billion over the period 1984–1989.

*Raising selected new or existing taxes*

In addition to large areas for revenue raising, a number of select excise taxes should be considered as possible sources of revenue:

Doubling the liquor tax will raise $2.7 billion in 1984.

Doubling the excise tax on beer and wine will raise $1.3 billion in 1984. These taxes were last raised in 1951.

Continuing the 16 cents a pack tax on cigarettes after September 30, 1985, will raise about $1.7 billion per year.

*Contingency Taxes:* The largest revenue increases recommended by the Administration are the so called "contingency taxes." If a set of preconditions—rather implausible in reality—are met, the administration would impose:

A $5 barrel tax on imported and domestic oil; and

A 5 percent surcharge on individual and corporate income taxes.

Aside from the merits or demerits of the specific taxes, the overall scheme as proposed would be disruptive to economic recovery. first, neither corporations nor individuals would know until fiscal year 1986 whether they would be affected. Secondly, the benefit of such taxes in reducing large out year deficits would remain uncertain. While the impact of any tax increases should take account of conditions in the economy, the certainty of such increases should not be in doubt.

## THE HEALTH COST CONTAINMENT TAX ACT OF 1983 (S. 640)

AARP cannot support the "Health Cost Containment Tax Act of 1983" which would tax the employee for employer contributions to health plans above a set cap. Though AARP recognizes that there are many good reasons for addressing the unlimited subsidy for health insurance fringe benefits authorized in the tax code, S. 640 is not an appropriate vehicle for achieving health cost containment. We do recognize, however, that potential exists in the tax code to create cost containing pressure on the private third-party payment system.

The "Health Cost Containment Tax Act" purports to serve a dual function: restraining the rise in health care costs and raising revenue. However, to the extent that one of these goals is achieved, the other cannot be realized. On the one hand, if substantial revenue is derived from these changes in the Internal Revenue Code, this is evidence that behavior is not being modified in the direction of containing health care costs. In fact, projected revenue to be generated by this bill is based on the assumption that consumer behavior will not be modified. On the other hand, if employer paid health insurance premiums are kept below the cap, then tax revenue will not be generated.

But the "Health Cost Containment Tax Act." cannot be construed as a means for achieving health cost containment because it fails to recognize the complexity of the incentives in the health sector. Failure to alter those incentives and curtail costs combined with the dampening effect which indexing the cap to the CPI (when premiums have been increasing at over 15 percent per year) will result in an unreasonable, precipitous erosion of health insurance benefits for workers and their dependents.

As a health cost containment device the theory behind the tax exclusion cap is that it would provide an incentive for employees to select cheaper plans offering less coverage and requiring greater cost sharing. The cost sharing would result in increased cost consciousness and less use of health services. But this theory is based on the assumption that employees can and would make different choices regarding their health insurance plans. Although little choice is currently available, as soon as choices become available the theory would begin to unravel.

If employees were to respond to the incentives by choosing between low and high option plans, then this may actually erode the insurance principle of spreading the risk of illness across a varied group. As the younger and healthier employees choose the low option plans, those with greater health care needs will choose high option plans. This "adverse selection" results in a high option plan that is extremely costly and thus difficult to insure.

It is widely held that employers and employees will respond to a cap by dropping coverage for preventive services and outpatient care before reducing protection against hospitalization. The concern is that as coverage for outpatient services is eliminated, the use of high cost inpatient services will increase. Such increased use of inpatient services would negate any cost containment effort.

As the Congressional Budget Office has pointed out, among group health insurance plans, premiums do not track closely with the level of benefits. Factors such as the size of the group, the average age of its members, and local medical prices and style of practice play major roles in determining group insurance premiums. It is these factors that make a uniform cap unfeasible. Since premium rates are directly affected by any one or combination of these factors, the uniform ceiling would not target the incentives to reduce insurance coverage on those with the most comprehensive benefits. For example, a small employee group with a high average age in an area where medical prices are extremely high may have little chance of having premium rates that fall within the cap. Even though the level of benefits may be modest.

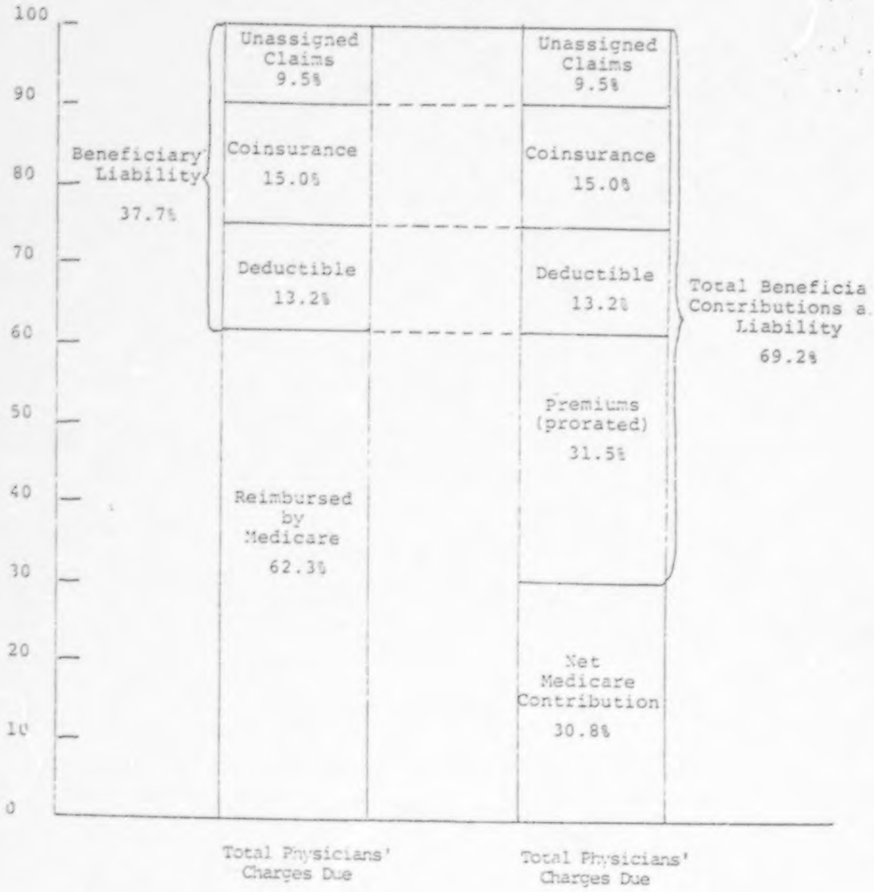
AARP is particularly concerned about the potential fallout for older workers resulting from a tax exclusion cap. Two areas of concern have already been discussed. First, to the extent that choices are available, older workers are more likely to choose high cost options due to higher rates of illness and utilization. As a result, they would immediately be thrust into a group where premiums are exorbitant. Second, since age is a factor in determining group health insurance premiums, employee groups with a relatively high proportion of older workers will find that the cost of group coverage is higher.

In those instances where the presence of older workers drives up insurance costs for all employees, a strong disincentive for employers to hire and maintain older workers is created. The discriminatory impact of the tax exclusion cap would likely be enhanced by TEFRA's "Working Aged" legislation whereby employers must offer the same health benefit package to workers age 65 to 70 as offered to younger workers. Younger workers may resent having to bear the increased costs attributable to older workers.

In summary, the "Health Cost Containment Tax Act of 1983" will not contain health costs. It is merely a revenue raising device thinly veiled in the rhetoric of health cost containment. Moreover, the extent to which S. 640 will actually raise revenue is questionable.

TOTAL PHYSICIANS' CHARGES DUE: COMPARISON OF MEDICARE REIMBURSEMENT WITH NET MEDICARE CONTRIBUTION FOR THE AGED: 1975

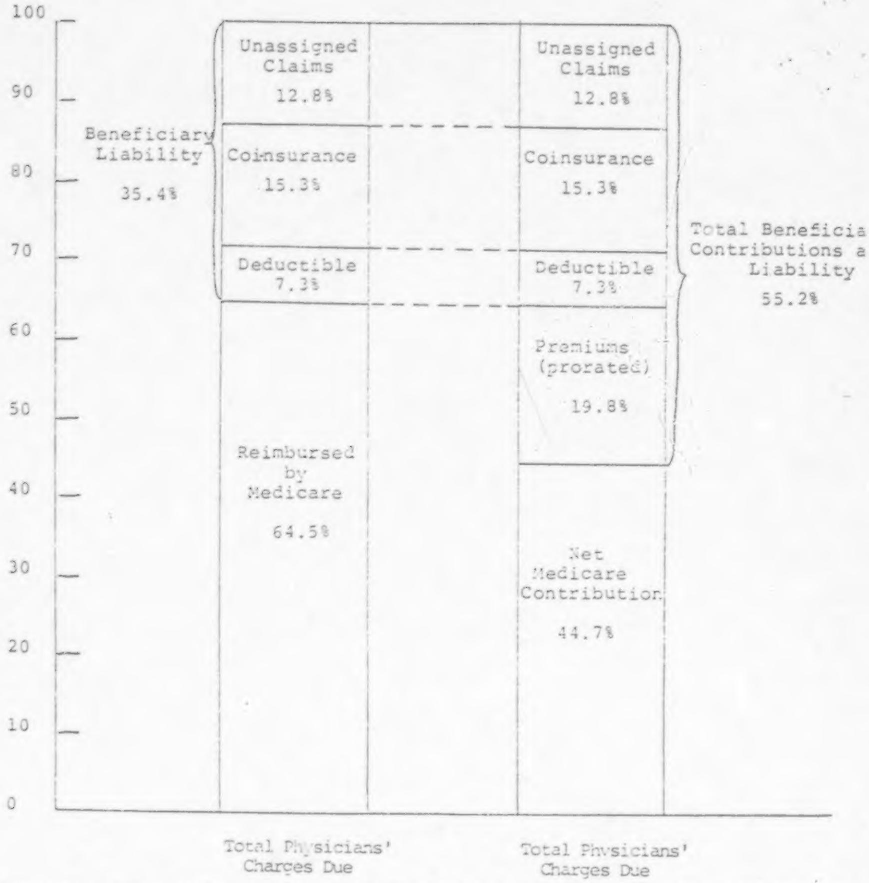
100% Basis



Source: Health Care Financing Review, Winter, 1980.

TOTAL PHYSICIANS' CHARGES DUE: COMPARISON OF MEDICARE REIMBURSEMENT WITH NET MEDICARE CONTRIBUTION FOR THE AGED: 1980

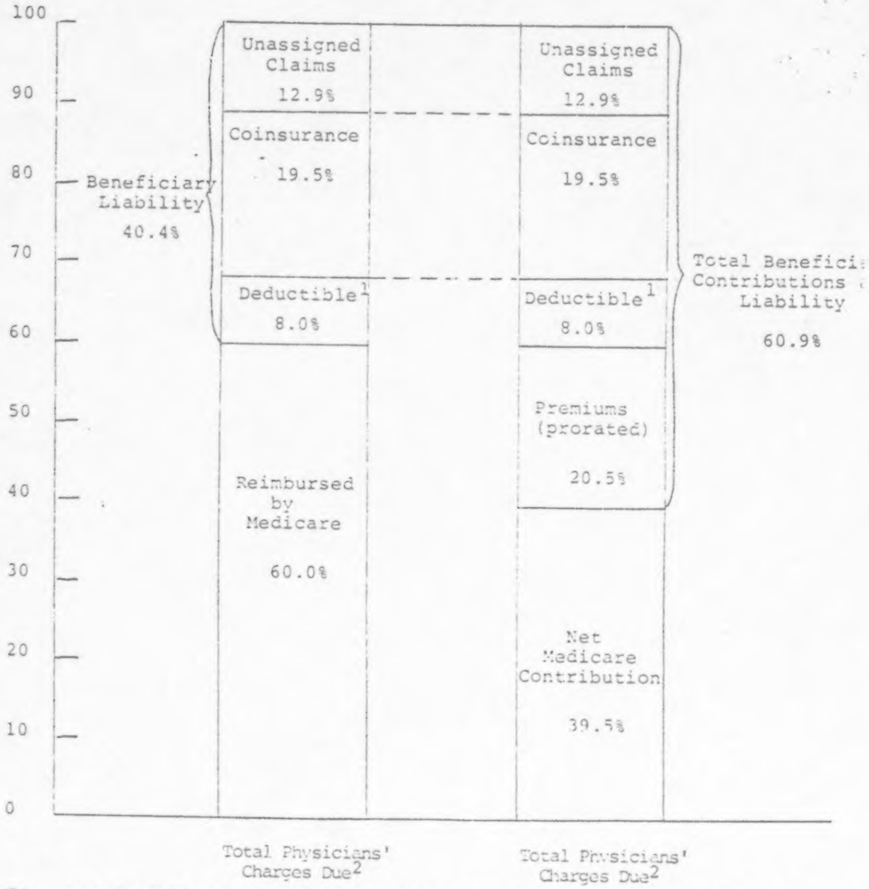
100% Basis



Source: HCFA, April, 1983. (Unpublished data). Figures are adjusted to include estimated expenditures made toward the deductible by thos beneficiaries who used services but did not meet the deductible; 1.1% of the deductible amount shown on this table can be attribut to beneficiaries who used physicians' services but did not meet the $60.00 annual deductible limit.

TOTAL PHYSICIANS' CHARGES DUE: COMPARISON OF MEDICARE REIMBURSEMENT WITH NET MEDICARE CONTRIBUTION FOR THE AGED: 1983 (Estimated)

100% Basis



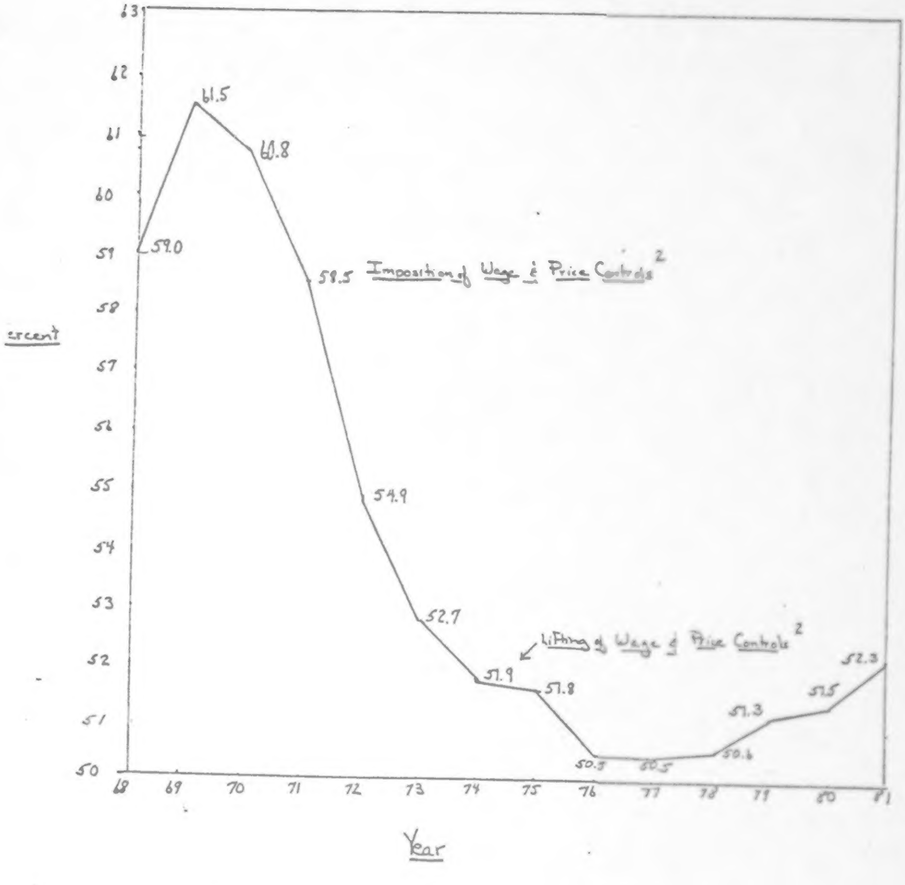
Sources: Data shown on table are based on figures appearing in Budget of the U.S. Government, FY 1984, OMB or provided by HCFA, April, 1983.

[1] An estimated 1.0% of the deductible amount shown on this table can be attributed to beneficiaries who used physicians' services but who did not meet the $60.00 annual deductible limit.

[2] Total percent exceeds 100% due to rounding.

ATTACHMENT B

## Physician Assignment Rate
## (1968-1981)



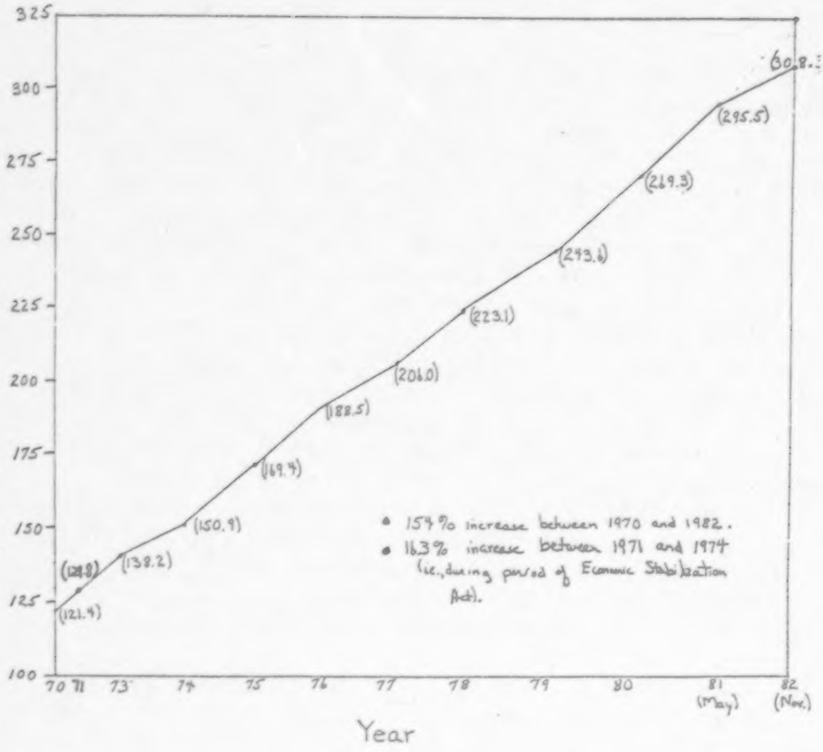
[1] Rate of acceptance of assignment based on total number of claims submitted.

[2] Decrease in assignment rate between 1971 and 1974: 11.5%

Source: HCFA

ATTACHMENT C

## Consumer Price Index: Physicians Services (1970-1982)



- 154% increase between 1970 and 1982.
- 163% increase between 1971 and 1974 (ie., during period of Economic Stabilization Act).

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[1] Annual average of monthly figures, with the exception of 1981 and 1982.

## STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS, WASHINGTON, D.C., ACCOMPANIED BY MISS JANET A. MYDER, DEPUTY DIRECTOR, OFFICE OF LEGISLATION AND RESEARCH, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. Hutton. Thank you, Mr. Chairman. I am William R. Hutton. I am executive director of the National Council of Senior Citizens. The National Council represents over 4.5 million elderly people in all 50 States and 4,500 clubs and the State councils. I am accompanied today by Miss Janet Myder, who is the associate director of research and congressional liaison for the national council.

Mr. Chairman, for the sake of time I will just briefly summarize this paper which I have already submitted. I would like to summarize our position with regard to the President's medicare budget proposals. And for the sake of the 4.5 million people we represent, I will, however, add to our emphasis that the President's medicare proposals are wrong, are excessively burdensome on the beneficiary, and are ineffective means of dealing both with devastating medical inflation and with the threatened trust fund shortage.

These policies would define cost containment as reducing the Federal Government's health care spending, but not that of the consumer. These policies also describe the budget cuts in medicare and medicaid as "savings." For example, the medicare proposals which would significantly increase beneficiary cost sharing through new part A copayments and higher part B premiums and deductibles are being requested under a plan called Health Care Incentives Reform. This plan would "provide medicare catastrophic coverage," but only six-tenths of 1 percent of all beneficiaries will qualify. It would improve medicare cost sharing, but all hospitalized beneficiaries will pay a $350 deductible, plus up to $1,180 for hospital stays which now require $304 deductible and no patient copayments.

The fiscal year 1984 budget proposals will force the beneficiary to wait longer for medicare eligibility, pay more for eligibility and services, and receive fewer benefits than under current law. We believe that these proposals will discourage beneficiaries from receiving needed medical care and encourage physicians to reject medicare assignment.

During the last 3 fiscal years, while the administration advocated budget cutting, and the Congress avoided wrestling with the powers of the health care system, medical inflation has left a trail of devastation. Health care prices have been growing at a rate triple that of the CPI—1982 medical inflation was 11 percent versus a CPI of 3.9 percent—medicare costs continue to rise at about 18 percent annually. The elderly beneficiaries' out-of-pocket health care burden has grown to an estimated $1,500 annually. Federal costs are being shifted to private payers at a rate of $5 to $7 billion per year.

Mr. Chairman, this is not cost containment. It is budget cutting and shifting of Federal costs with little regard for consequences and no attempt to make the health care system economically efficient. For the elderly, the recent attempts at Federal cost savings have only increased an already heavy burden. The aged need more comprehensive health care services than the under 65 population. However, medicare covers only 44 percent of their medical expenditures. The medicare beneficiary now pays 20 percent of his or her income on health care, as great a proportion as was spent before medicare was enacted. Yet health cost containment to this administration means increasing and increased beneficiary cost sharing.

The President's health incentives reform package presumes that the consumer of health care can play a key role in cost containment. The major premise is that increased cost sharing will create a cost-conscious consumer who will demand fewer allegedly unneeded services and somehow pressure doctors and hospitals into cost-efficient behavior. Such proposals are not only ludicrous, they will not produce an economically, efficient health system. They will simply force the elderly to pay more for their care or forego receiving medical attention.

The principal decisionmakers in the health system, primarily the providers, whose decisions feed inflation, will have no incentive to change their behavior.

Mr. Chairman, Congress should be asking: Will beneficiary cost sharing render the health system efficient? Will it change provider behavior? The answer to both questions, we believe, is no. Thank you, Mr. Chairman. I will conclude.

Senator CHAFEE. Thank you very much, Mr. Hutton.

[The prepared written statement of Mr. Hutton follows:]

### STATEMENT BY WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. Chairman, I am William R. Hutton, Executive Director of the National Council of Senior Citizens. The National Council represents over 4.5 million elderly persons in all 50 states through over 4,500 clubs and state councils. Our organization was founded during the long struggle to adopt a Federal health insurance program for the aged: Medicare. Over the years we have worked toward the goals of a better life for senior citizens—one with dignity, as well as income and health security.

We believe that achieving these goals requires a Medicare program with secure financing and adequate benefits. We are afraid, however, that the President's fiscal year 1984 budget proposals will jeopardize both of these conditions.

Mr. Chairman, since the President submitted his fiscal year 1984 budget proposals, the National Council of Senior Citizens has appeared before the Congress several times to discuss the Medicare proposals. Our most recent appearance was on May 16, 1983, when NCSC's President Jacob Clayman appeared before this Committee's Health Subcommittee to give our views on the beneficiary cost-sharing provisions in that budget. Mr. Clayman's written statement is available for today's hearing record.

For the sake of time, I would like to briefly summarize NCSC's position on the President's Medicare budget proposals. For the sake of the 4.5 million older persons we represent, however, I will add to our emphasis that the President's Medicare proposals are wrong, are excessively burdensome on the beneficiary, and are ineffective means of dealing both with devastating medical inflation and with the threatened trust fund shortage.

The rising costs of health care and the Medicare program have alarmed members of the Administration and the Congress and they are seeking cost-reducing strategies. It is appropriate to do so, however, the policies adopted thus far and now being debated for fiscal year 1984 are misdirected, ineffective and unfair. These policies would define "cost-containment" as reducing the Federal government's health care spending but not that of the consumer. These policies also describe budget cuts in Medicare and Medicaid as "savings."

For example, the Medicare proposals which would significantly increase beneficiary cost-sharing through new Part A co-payments and higher Part B premiums and deductibles are being requested under a plan called "Health Care Incentives

Reform." [1] This plan would "Provide Medicare catastrophic coverage," but only six-tenths of one percent of all beneficiaries will qualify. It would "Improve Medicare cost-sharing," but all hospitalized beneficiaries will pay a $350 deductible, plus us to $1,180 for hospital stays which now require $304 deductible and no patient co-payments.

The fiscal year 1984 budget proposal will force the beneficiary to wait longer for Medicare eligibility, pay more for eligibility and services, and receive fewer benefits than under current law. We believe that these proposals will discourage beneficiaries from receiving needed medical care and encourage physicians to reject Medicare assignment. What will these proposals accomplish? Cost-containment? Long-term savings? We doubt it. Even short-term budget savings are questionable in view of recent history.

During the last three fiscal years, while the Administration advocated budget cutting and the Congress avoided wrestling with the powers of the health care system, medical inflation has left a trail of devastation. Health care prices have been growing at a rate triple that of the CPI (1982 medical inflation was 11 percent versus a CPI of 3.9 percent). Medicare costs continue to rise at about 18 percent annually. The elderly beneficiaries' out-of-pocket health care burden has grown to an estimated $1,500 annually. Federal costs have been shifted to private payers at a rate of $6–$7 billion per year.

Mr. Chairman, this is not cost-containment. It is budget cutting and shifting of Federal costs with little regard for consequences and no attempt to make the health care system economically efficient. The Congress and the Administration have failed to pursue true cost-containment derived from controlling the inflation-driving incentives across-the-board. Consequently, more and more people of all ages are finding affordable health care a luxury. Yet instead of tackling the health system head on, the President is asking for further cuts in Medicare and other public health spending.

For the elderly, the recent attempts at Federal cost savings have only increased an already heavy burden. The aged need more comprehensive health care services than the under-65 population, and the expenditures they incur for care are three times greater than those of younger persons. However, Medicare covers only 44 percent of the elderly's medical expenditures due to rising medical costs and an inadequate benefit package.

The Medicare beneficiary now pays 20 percent of his or her income on health care—as great a proportion as was spent before Medicare was enacted. Yet health cost-containment to the Administration and many members of Congress means Medicare budget cuts and increased beneficiary cost-sharing.

The President's Health Incentive Reform Package presume that the consumer of health care can play a key role in cost-containment. The major premise is that increased cost-sharing will create a cost-conscious consumer who will demand fewer allegedly unneeded services and somehow pressure doctors and hospitals into cost-efficient behavior.

The Medicare beneficiaries' contribution to this "cost-containment" scheme would be to pay a higher Part B premium and deductible and a new Part A co-payment. The beneficiaries therefore would share not only part of the Federal government's Medicare costs, but also a large portion of its responsibility for cost-control.

Such proposals will not produce an economically efficient health system. They will simply force the elderly to pay more for their care, or forego receiving medical attention. The principal decision-makers in the health system, primarily the providers, whose decisions feed inflation, will have no incentive to change their behavior. (The DRG system was enacted in hopes of changing provider behavior but we suggest: "Don't count on it." DRGs have not been proven effective yet; the plan will allow cost-shifting since it is applied only to Medicare; and hospitals could "game" the system at great cost to beneficiaries' health and program financing.)

Again, I suggest this is not cost-containment. Cost-sharing is merely a euphemism for cost-shifting. It is ironic that many members of Congress are now expending considerable energy trying to figure out where they can apply cost-sharing, that is, increase beneficiary out-of-pocket costs, so that the least burden will be felt. Some are considering a means-tested approach. Not only does this approach ignore the level of beneficiaries' medical needs, it also asks the wrong questions.

The Congress should be asking: will beneficiary cost-sharing render the health system efficient? Will it change provider behavior? The answer to both questions, we believe, is *no.* It will instead shift federal costs to the elderly and disabled Medicare beneficiary and allow inflation to continue. Such a policy will force Congress to return for "savings" year after year to the Medicare beneficiary and to other recipients of Federal health programs.

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[1] Department of Health and Human Services Budget Fact Sheet.

The National Council of Senior Citizens considers the Administration's and Congress' current approach to be poor public health and budget policy. There are better ways to save Medicare dollars. Since Medicare spending reflects the inefficiency and uncontrolled spending in the larger health system, cost-saving plans must begin with the entire health care system.

Unless and until the costs of our health care system are brought under control, no amount of cost-sharing or other budgetary devices will help Medicare. Furthermore, the cost to the beneficiary of such ineffective strategies is too great. There is sufficient time for Congress to adopt carefully developed and equitable methods outside of the budget process to assure beneficiary protection and trust fund solvency.

We believe that Congress has the obligation to control the rising cost of health care for the benefit of all citizens, and that this can be accomplished through a sensible constructive approach. Many plans are under consideration and others are being developed. Senator Kennedy has proposed S. 814, one of the most reasonable plans to be brought forth in this Congress. There will be others.

The plans that can succeed as true, equitable cost-containment are those which instill economic efficiency into our health system. They are targeted to the causes of rising costs and to the real decision-makers in the system. With a firm Federal commitment, these plans call for prospective payment to assure that the providers take the financial risk for their actions. The plans include all payers and all providers to avoid cost-shifting. The plans that can succeed also assure quality of care and preserve access to services, without increasing the financial burden on the beneficiary.

The promising plans also require the states to participate in cost-control programs. The experience and success of all payor state plans, such as those in New Jersey, Maryland, New York, and Massachusetts, are valuable. Federal legislation is needed to encourage all states to develop their own plans.

Are such cost-containment plans possible? The NCSC believes they are, but not as long as the Congress seeks short-term budget savings regardless of the cost to people.

We believe that across-the-board cost-containment initiatives should be the major focus of Medicare program savings. Consider that three out of four Medicare dollars are spent on hospital care. Across-the-board cost-containment that slows the increase in hospital costs, rather than shifting Federal costs, will generate savings for Medicare and for private insurors, individuals, employers, and others who now bear shifted costs.

Changes within the Medicare program could also be made to generate savings while improving the benefits package to more closely meet the elderly's medical needs. For example, plans which seek more extensive coverage of non-institutional services will better use Medicare dollars now spent on unnecessary and expensive institutional care when alternative services would suit the beneficiary's chronic care needs more appropriately.

Such plans represent better use of the Medicare dollar. This, we believe, is a direction that Congress should pursue, along with health system-wide plans to slow the rising cost of health care. These two approaches will assure savings without sacrificing citizens' access to the quality, appropriate health care service they need. We urge the Congress to take this approach to saving health care dollars.

Senator CHAFEE. Now, both of you made your points very strongly about not having the medicare beneficiaries pay any more, and indicated that the problem is with the rising health costs. That is true. The question is, How do you do something about it? Now, Mr. Hutton seems quite certain that the cost-conscious consumer will not affect the rate of increase. I read forward in your statement, which you did not have time to cover, and you indicated that prospective reimbursement covering all payors is the route you suggest we follow.

Mr. HUTTON. It is one of the ways. We are not sure about it yet. It is just an experiment. We will wait until the results come in on DRG.

Senator CHAFEE. One of the problems—and this goes back to Mr. Hacking—is that the part B premium has risen 88 percent over the past 5 years, which you point out. During those 5 years, the share of part B paid for by the beneficiary has dropped below 28 percent. Now you are familiar that when this program started it was designed for the beneficiary to pay 50 percent. What is your answer to that?

Mr. HACKING. Well, I would just say, Senator, if we proceed to implement what the administration has proposed, namely, increasing the portion of the part B program cost that the elderly carry via the part B premium from 25 percent, which is now the law, to 35 percent over the period 1984 to 1988, we are going to see the premium go from where it is now at about $146, to approximately $400. That would be a very substantial increase in out-of-pocket cost for the elderly. As you know, they are already covering roughly 40 percent of their per capita health care bill out of pocket. Moreover, we don't see that increasing their share of out-of-pocket cost for health care services is really going to solve medicare's cost escalation problem. All you would be doing is substituting the elderly themselves as payors in place of the program—and the taxpayer—to an increased degree. Providers would continue to do business as usual.

Senator CHAFEE. Well, we have an awful problem here. We are not going to solve it this morning, but we have a very severe problem which you are familiar with as much as anybody here, namely, that the cost of medicare is going right through the roof and we can say that the medicare fund will be broke in 3 years; 1988 seems to me to be the figure they kick around most. So what are we going to do? What is your answer?

Mr. CORRY. Senator, if I might add to Jim's remarks. We need to go back and look at the history of what has happened on the part B premium rate since it was set initially at 50 percent. Two things happened which upset that design. First, in the mid-seventies the Congress introduced new populations to the medicare program, and appropriately so, that had a different utilization rate than the elderly.

That is, the Congress introduced the disabled and end-stage renal populations, both appropriately so, but, nonetheless, they did have an effect on the premium's share of cost.

Senator CHAFEE. What were the two groups?

Mr. CORRY. The disabled and end-stage renal populations.

Senator CHAFEE. I wonder if those could have significantly affected the national statistics.

Mr. CORRY. To the extent that they have a different utilization rate, a higher one, they would. I think your staff could probably inform you on that more than I can here today.

Senator CHAFEE. Go ahead.

Mr. CORRY. The second factor, and probably the larger one, is when the automatic cost-of-living adjustment—COLA—took effect for social security, Congress linked the maximum increase in the part B premium to the increase in the COLA to avoid the situation of social security checks actually dropping in amount. As you know the part B premium is deducted from the beneficiary's check. Because medical inflation, was then, and is continuing to rise at such a rapid rate above general inflation—at two and three times general inflation—an increasing gap has been created between the CPI indexed COLA increase and the increase in medical inflation. So you are correct, there has been a slip in the amount of payment.

Senator CHAFEE. CPI is based on a whole series of factors and thus that results in and is applied to the overall social security check that the beneficiary receives. Even if it is a lower percentage, you are working on a far bigger base.

Mr. CORRY. Your are correct. Apparently however, the Congress did not want to have social security checks actually dropping in amount. While the check was supposed to go up from the COLA to offset general inflation, unfortunately, medical inflation was going up so much faster that had you continued the part B premium at the 50 percent rate, social security checks would have declined successively in amount over the years.

Senator CHAFEE. Well, we have got a tremendous problem here. I just would read to you something that I saw in a modest column in the paper the other day that has, in my judgment, extraordinary ramifications for the future of this country in the programs that you are interested in and we are struggling with a meeting of the American Association for the Advancement of Science in Detroit where the predictions were made by the gerontologists that the expected longevity of Americans would increase in the following manner by the end of this century, 17 years away. Men go from 64 to 70 years life expectancy; women from 78 to 86 years. I believe these statistics. I personally felt that when we were dealing with the social security changes here last January that, for some reason, nobody tackled the increased longevity of Americans to the extent that it should have been. So, I don't think we really solved the problem. These statistics, estimating a life expectancy for women of 86, are going to knock every program we have to care for the elderly. So what we are struggling with in medicare now is nothing compared to what is going to happen in a few years unless we do something.

Well, my time is up, and I have got some more questions when we get back. Senator Long?

Senator LONG. No questions.

Senator CHAFEE. Senator Bradley?

Senator BRADLEY. Thank you, Mr. Chairman. I would like to address my question to both Mr. Hacking and Mr. Hutton. What pressures are generated in the administration's budget proposals that increase out-of-pocket acute care hospital cost to the beneficiaries, plus the DRG? Do you think that a combination of these two things would create even greater need for some kind of home care for the elderly?

Mr. HACKING. Well, Senator, first of all, with respect to the prospective payment scheme and the DRG system, AARP supported the concept. However, we think that what was enacted was deficient in a number of respects, the most important of which was that the prospective payment system was not applied across the board, to all third party payors; it is medicare specific. It should have applied to all third-party payors. If in the absence of the prospective payment system applying to all payors, you have one that just applies to medicare, what you are going to get is hospitals shifting their costs onto other payors. Thus we'll get no change in hospital cost escalating behavior and no dampening of the overall rate of escalation in hospital costs.

Now what that means is that the resources (namely the tax payments of payroll taxpayers and the premiums paid by employers) that are pumped via third party payors into the medical care system will continue to flow automically into hospitals. Thus we will always have too little resources remaining to begin to implement the kind of integrated, long term care program that is critically needed to accommodate the demographic shift taking place in the population.

Senator BRADLEY. The long term care program meaning care in the homes?

Mr. HACKING. The care in the home included, sure. We view the need for a long term care program as not just a need for a nursing home or institutional services, but the need for the whole continum of long term care services, including home care and including not just medical care but also supportive social services.

Senator BRADLEY. Thank you, Mr. Hutton?

Mr. HUTTON. My feeling is that whether or not we have a DRG system, it has to be improved. And if you cut down on hospitalization then obviously you are going to need perhaps more home health care. And I would be for that. I think we could also save money in such a way. However, it does seem to me—with reference to the Chairman's remark earlier—that that bell is tolling for all of us.

Senator BRADLEY. Mr. Hutton, if you could, could I just ask a couple more questions?

Mr. HUTTON. Yes, sir.

Senator BRADLEY. It's Not that I don't want to hear what you have to say about Senator Chafee's observations. Do you think that at the same time we are considering whether to increase the out-of-pocket acute care costs to beneficiaries, we should at the same time consider at least a modest initiative in the home health care area?

Mr. HUTTON. Yes, I do. I think it should. We should have that kind of initiative. It has not been tried at all. It is being neglected.

Senator BRADLEY. Mr. Hacking?

Mr. HACKING. Yes. AARP agrees with that, Senator. We have endorsed your bill, the bill that you authored with Senator Packwood to establish a title XXI. I guess the problem has been in defining the size of the population that would be served accurately in order to come up with a price tag for the legislation.

Mr. HUTTON. I would like Miss Myder to answer that question, too, my associate.

Senator BRADLEY. All right.

Miss MYDER. I would just like to add to Mr. Hutton's comments and that is whether it is through a DRG plan or through more appropriate use of hospital care, if the demand for home health care increases—and we believe that the demand is already there, and that there are many people who are institutionalized who should not be—and one of the alternatives would be expanded home health care benefits. We agree that this should be pursued. However, under current medicare law, the restrictions are too great. For example, the medical necessity.

Senator **Bradley**. So you would support the idea of loosening those restrictions, at least for the disabled elderly?

Mr. **Hutton**. Yes.

Miss **Myder**. We do, to make it easier for the people who need care to receive it at home or in a community setting rather than be institutionalized, and to say they need skilled medical care and have to require a certain level of care makes it too difficult.

Senator **Bradley**. Thank you, Mr. Chairman.

Senator **Chafee**. Do you think it would do any good if we did away with the 3-day hospital stay requirement before a person went into a nursing home? Mr. Hutton?

Mr. **Hutton**. Yes, I do. I do think it would be a useful thing to experiment with removal of it anyway. I thought we had put it into the law at one time.

Senator **Chafee**. What do you say to that, Mr. Hacking?

Mr. **Hacking**. That is something we support, Senator. But my understanding is it has been done.

Senator **Chafee**. Well, this idea is being studied now.

What I am struggling for is some help in solving these problems of the Medicare Fund. I suppose, quite logically, representing the organizations you do, you resist the suggestions.

Mr. **Hutton**. But we do not resist the idea of tackling the problem, Senator. What we cannot understand is why you insist on only tackling medicare problems when medicare's problems are the result of our terrible health system nationally, where inflation is allowed to go on without any stop at all. There is no attempt, by any government, at cost containment. The reason why medicare costs are going up is because Government is buying medicare, or care, too expensively today. And it should be reduced, and could be reduced by efficient methods, by tackling this thing properly. Tackle it as a whole and you will get the medicare problem solved. If you just try to tackle one little piece and expect medicare to take care of the whole Nation, that is not going to happen.

Senator **Chafee**. I don't think anybody thinks that medical costs are going to increase only at the rate of inflation. They are leaping ahead.

Mr. **Hutton**. Not because of medicare.

Senator **Chafee**. I mean hospital cost. Maybe there is hope out there, but I really came to the conclusion that hospital costs will increase at a greater rate than the CPI.

Mr. **Hacking**. Senator, may I comment?

Senator **Chafee**. Yes.

Mr. **Hacking**. Hospital costs increased at the rates that they did because of the incentives that exist in the marketplace. Since health care is now the third biggest industry in this country today, it is going to take a very long period of time to change those incentives in the marketplace. We need something immediate to rescue medicare. The CBO projections that conclude that part A of medicare is going to be unable to pay its bills on time, as early as 1987, indicate that the program costs, medicare's costs, are going to go up on average 13 percent a year; 10.8 percent of that 13 percent is attributable to the escalation in hospital costs. Unless you put a constraint, an across-the-board constraint, in place immediately, on hospital costs, the program is going to be insolvent. Those CBO projections assumed the projected savings entailed through the implementation of the TEFRA limits and now the prospective payment system; still something more is needed.

Senator CHAFEE. Are you prepared to accept a reduction in the advancement in medical care?

Mr. HACKING. The acquisition of more hospital plant and more equipment does not always translate into more quality care, nor does it necessarily translate into better health status or longer life for the population. You could probably get for the same amount of additional resources a greater improvement in health status for the population by putting those same resources into better nutrition or improvements in the environment. But under the current system, those resources will go automatically into more hospitals and everything that the hospitals consume.

Senator CHAFEE. Well, let me change gears. I would note for the record that Mr. Hutton testified that he does not believe that a cost conscious consumer will demand fewer medical services. Let me ask you this. When we made the changes in social security last January, in effect, we put in a means test. People won't say it was a means test, but indeed it was a means test when social security becomes taxable, after it does, when you reach certain brackets. Now what about a means test in medicare? What are your thoughts on that?

Mr. HACKING. Well, we were opposed to the introduction of a means test into social security. And, Senator, we did label the taxation of benefits as a back door means test.

Senator CHAFEE. It was.

Mr. HACKING. We are equally opposed to a means testing of medicare.

Senator CHAFEE. Well, why should the Federal Government help pay the medical costs of somebody with $1 million a year of income?

Mr. CORRY. Senator, if I could take a shot at that. Medicare is not a cash assistance program. It is a program which provides services to people who are sick or need medical care in order to prevent more serious and more costly health care problems.

One of the problems that you get into when you begin to look at means tests of any kind is the huge administrative costs. To set up a means test for the medicare program you would have to somehow administer a test probably on some sort of an annual basis to 30 million beneficiaries. There is no similar program out there now. The medicaid program is, of course, piggybacked on other programs and does not provide a very good analogy.

Senator CHAFEE. I understand by your answer that you are not opposed to it in principle. Are you just opposed to it as a result of administrative costs?

Mr. CORRY. We are opposed to it in principle, but I am also trying to give you some reasons why, in practice, it would not be a very good idea.

Senator CHAFEE. Well, explain to me why you are opposed to it in principle.

Mr. CORRY. In the first case, medicare is a program which is financed, in the case of part A, from a payroll tax program. Increasingly, more and more beneficiaries will have paid into that program through their payroll taxes throughout their working life. They have come to expect that, regardless of income, they will be protected in the health care area.

Senator CHAFEE. We can also advance on the assumption that what they are paying does not adequately cover the expected costs.

Mr. CORRY. Currently, as you know, part A is paying for its cost. The projections for part A's problems in 1988 are not primarily due, according to CBO's most recent analysis, to increases in the number of beneficiaries, but rather to inflation in hospital-medical costs. Of the 13.2 percent increase projected for hospital costs, only 2 percentage points of that is attributable to more elderly.

But a second point which I would make to you is when we look at health and who utilizes health care, a means test more or less implies that somehow we can control health care costs by either eliminating or increasing the cost to upper income beneficiaries, when, in fact, they are not, by and large, the ones pushing up the cost. The heavy costs in health care come from the oldest and the poorest among the elderly. If you look at the utilization patterns, if you look at where the greatest costs are, they are in the last year of life. And there is a tendency also not only for the elderly but across the population for higher health care cost if the income is lower.

So quite aside from our differences in principle, I think, in practice, it is not going to produce the kind of savings that people feel make it attractive.

Senator CHAFEE. Well, I noticed that you have stated, and Mr. Hacking has stated, his concern for the deficits. I share that concern. We have a terrible problem here. Not just today, but every day, witnesses come before us either asking us to spend more money or telling us not to make any savings, while the country is running a $200 billion deficit. To me that is wrong. That is immoral. I remember when Governor Warren was Governor of California. He said the people of California can have anything they want as long as they are willing to pay for it. We have a situation in the United States where people want everything, but they don't want to pay for it.

Mr. HACKING. Well, Senator, may I say that in my opening remarks I did say that.

Senator CHAFEE. Yes; you showed concern for it, but you did not give us a solution.

Mr. HACKING. I did say that to get those deficits down we are going to have to pay for what we get, whether it is armaments or whether it is domestic programs, that serve the people.

Mr. HUTTON. Senator, don't you think that the people who have paid their medicare premiums for all of these years, have a very good case, against the Federal Government, particularly the Congress, for not enacting good cost containment proposals to give them value for their money? They are not getting value for their money, and the Government is not doing anything about it.

Mr. CORRY. Senator, I would point out two other things. One, as I think you know AARP did support TEFRA last year, even though there were provisions both in the spending and the revenue areas with which we took exception.

Senator CHAFEE. Yes; Mr. Hacking said that in his statement.

Mr. CORRY. And a second point that I would make is, if you look at the projections of what will contribute to the structural deficit between now and 1988, the policy actions taken by the Congress within the last 2 or 3 years will contribute a net reduction in the deficit of almost $400 billion by cuts in nondefense spending programs, whereas, defense spending increases will add $285 billion to that deficit, and the tax reduction will add another $860 billion to that deficit between now and 1988. So I think what we are saying is that many of the programs and many of the beneficiaries who we represent have borne a good deal of the burden of deficit reduction in the past few years. We would like to see a little more sharing by other segments of the budget.

Senator CHAFEE. Well, thank you very much for testifying, gentlemen. We appreciate it.

Mr. Owen and Dr. Malach.

All right, Mr. Owen. Where is Dr. Malach?

[No response.]

Senator CHAFEE. All right, Mr. Owen, we have heard where the problem lies. Why don't you tell us how to solve it?

## STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, CHICAGO, ILL.

Mr. OWEN. Thank you, Mr. Chairman. I am Jack Owen, representating the American Hospital Association, which represents the majority of hospitals in the country. After listening to the last two witnesses, I don't know whether I should even be sitting here. But I would find it of interest to the committee that in the last survey we did, an independent survey, about 80 percent of the people in the country were very happy with their hospital service. So there has got to be something wrong.

Senator CHAFEE. Well, the people are happy with their medical service, but those people never see the bill; that is one of the problems. Few people who use the hospitals even see the bill. They pay a pittance to be relieve of it; I have experienced this myself with members of my family. I never even know what the bill is nor do I question it. I pay my modest amount, leave, and turn the rest over to the insurance company.

Mr. OWEN. That is exactly right. That is what I would like to talk to you about today.

Senator CHAFEE. All right. Let's hear it.

Mr. OWEN. All right. You have my written submission. I would just like to have time to just comment on it.

First of all, there has been a reduction in the inflation in health care in this first year. I don't think too many people understand or know that, but the rate of inflation has dropped almost 6 percent in the first quarter of this year and we expect it will hold through the rest of the year. So there are some things happening.

Second, TEFRA, which was enacted last year, has not really had a chance to be effective yet. A third of the hospitals don't go on the first year of TEFRA until July 1 of this year. For instance, all the hospitals in Pennsylvania, who have a fiscal year ending on July 1 would not be going on until this July. So it is not even the first year of TEFRA. Now, we have got a prospective payment system which starts October 1 of 1983, with the DRG's. We think it ought to have a chance to operate and have an opportunity to show whether there will be a change in behavior and change in incentives.

You hit upon one of the keys a little bit ago when you talked about the number of aging. There is no magic in this delivery of health care. I saw in the paper the other day that there are now 32,000 people over a 100 years old, and that since 1980, the census of 1980, the over 85's have increased 9 percent. That is wherein lies much of our problem.

Well, we started on a new system. We believe that it is going to change some incentives. I have been traveling around the country talking to hospital people in all parts of this country. I am seeing some changes take effect. We are going to see some changes in behavior as we look at this new DRG system, and it is going to eliminate some of the cost shift that everybody keeps talking about.

One of the misconceptions in the whole issue of cost shift is that hospitals really do not shift costs, they shift where they get their revenue from. If the costs are there, they need to get the revenue from someone else; they have to get that revenue from somebody else because there is no such thing as free care.

But what happens in a program like the prospective payment system and the TEFRA system is that as the hospitals have an incentive to hold down costs and everybody benefits from it—the private insurer and the man who pays his own bill—because once the cost is lowered, there is not as much of a need for revenue, as long as those costs are paid for. So we think we have taken the first step. Congress has taken the first step.

Some people say that there has not been any holddown in costs; that Government has been negligent in holding down costs. I would remind you that under TEFRA, we are in a budget neutral situation in which we have a fixed pot of money, and there will be no more money in the pot. So any of these programs that we are talking about all have to stay within the amount of dollars that the Medicare Trust Fund has.

So we have taken the first step. We have got some incentives now for hospitals. It seems to me that we ought to be talking what that second step is, and I think that leads to what you were talking about a minute ago. That is, how do you get some consumer incentives? We have discovered that, just as you have, that when no one pays their bill, and the insurance company pays it for them, there is not as much interest in the kind of care that the person selects, or the appropriate place where that care is delivered. Senator Bradley commented about home health care. We think that is a wise decision, a way to go. There are a lot of ways to go.

But as long as no one has to worry about participating in the cost of their health care, they are not going to be concerned as to whether they go to the least expensive hospital or the most expensive, and they do not care about it.

Senator **Chafee**. Do you dispute the statement of Mr. Hutton, where he said, on page 4 of his testimony, "A major premise is that increased cost sharing will create a cost-conscious consumer who will demand fewer or electively unneeded services, and somehow pressure doctors and hospitals into cost efficient behavior." You don't agree with that?

Mr. OWEN. I agree that, if I understood it right, he is saying he does not believe that that will happen. All right. Yes, I disagree with that.

Senator CHAFEE. He disagrees with that premise.

Mr. OWEN. Yes. I disagree with him. I think that it does make a difference, and I think there has been enough demonstrations and enough activity in this field to know that it does. The whole HMO movement was an example of why people went into HMO's, because it was a way in which they got a better way to get taken care of with less expense.

So we really feel that there has to be some participation. The medicare program is not a program for the poor, it is a program for the aged, and you have well pointed out, the means test possibility. There are people who can afford to pay, and they should pay if we are going to see any change in their behavior as well as hospitals.

Now, let me give you an example. Back when Herb Dennenberg was the insurance commissioner in Pennsylvania, he put a little book out that said what the cost of hospital care was in the Philadelphia area, and tried to encourage people to go to the least expensive hospital. But they all had Blue Cross, and Blue Cross paid the full bill. So what happened was, people looked at the little book and said that if they went to this hospital it only cost $100 a day, but if they went to this one it cost $300 a day. I had better go to the most expensive because I am not paying for it anyway. That is exactly what happened. It backfired.

Unless you participate, you are not going to have the incentive to shop around. So we really think that there needs to be more participation.

We are a little concerned about the kind of participation that the administration is talking about because we are in a new pricing system, with the old system of basing the deductible and the copayment on cost. We are off that system. We think cost-sharing should be changed so that the patient does not necessarily pay more, but he has a better selection of where he goes, and uses the pricing mechanism rather than a cost mechanism. Instead of paying $350 for every hospital he goes into, there may be a difference in the price of that case under the DRG system. Basing cost-sharing on the DRG price he pays less and selects the lower priced hospital. So he doesn't have as much coming out of his pocket. We need that incentive.

But I notice my time is running out. I do want to talk about one other thing because there is one other problem with this whole situation and that is the medicaid problem. The medicaid program is a program for the poor, unlike medicare. We think the idea of asking medicaid people to participate is counterproductive and could lead to access problems. Reduction of the medicaid program is going to hurt the inner city hospitals and it is going to hurt some of the States that have already cut back. We think this is one of the areas where we have to take a harder look to see that the poor people are taken care of, and that cost-sharing will create a problem.

We also are concerned about the unemployed in Detroit and some of these areas where there are high unemployment rates, and we support the tax cap as a way to raise the revenue to pay for health benefits for the unemployed. We think that is one good way to do it. It spreads it across everybody from the standpoint that everybody begins to look at what their premiums are, what their health care coverage is. If they start to pay a tax, maybe other people, other than the elderly people, will take a look and see what kind of health care they are getting. This would provide some revenue to take care of those people who cannot have health care.

Senator CHAFEE. What are your views on the medicare voucher?

Mr. OWEN. We are in favor of a medicare voucher. We have seen some experiments that are going on in Florida that have some merit. We think before it is implemented in the market for everybody that it ought to be looked at carefully to see what the pros and cons are. But we are very much in favor of support of that kind of a system.

Senator CHAFEE. Thank you. Dr. Malach?

[The prepared written statement of Jack Owen follows:]

### STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman and members of the Committee, I am Jack W. Owen, Executive Vice President of the American Hospital Association (AHA). The AHA is the principal national organization of hospitals, representing 6,300 hospitals and 35,000 personal members. Thank you for giving me the opportunity to present the AHA's views on the Administration's Medicare and Medicaid spending reduction proposals.

The AHA views the Administration's Medicare and Medicaid spending reduction proposals as an important first step toward reforming financing of the health care system. For too long, the federal government "tinkered" with the Medicare and Medicaid programs in an effort to control the rapid increase in health care spending. But this tinkering proved counterproductive. Medicare outlays grew from $4.7 billion in fiscal year 1967, when the program was enacted, to $46.6 billion in fiscal year 1982, with estimated outlays of $59.8 billion projected for fiscal year1984 if the Administration's proposals are accepted. Federal Medicaid outlays increased from $1.5 billion in fiscal year 1967, to $17.4 billion in fiscal year 1982, with $21.0 billion estimated for fiscal year 1984.

Even more alarming is the projected insolvency of the Hospital Insurance (HI) trust fund. Recent estimates indicate that the HI trust fund will be depleted by the end of this decade, with a deficit of between $300–400 billion in 1995.

Clearly, the past regulatory solutions to health care costs have not and will not work. A more competitive approach to Medicare, one that would change incentives for both consumers and providers, and encourage the use of the lowest-cost providers, is needed. The competitive approach is mainly characterized by prospective pricing, enacted this spring to change cost incentives under Medicare; the Administration's proposal for restructuring Medicare Part A; and the experimental use of vouchers.

My statement will focus on these competitive approaches, other selected Medicare spending reduction proposals; and two of the Administration's proposals for Medicaid: the federal match reduction and mandatory copayments.

#### MEDICARE PROPOSALS

##### *Part A restructuring with catastrophic protection*

Medicare currently covers only 90 days of inpatient hospital care per spell of illness, with a special lifetime reserve of an additional 60 days. There is no patient cost sharing for the first 90 days of any spell of illness, after the first day deductible of $304 ($350 in 1984). Coinsurance of $76 per day is required for days 61–90, and this increases to $152 for 60 lifetime reserve days. Medicare also covers up to 100 days of care in a skilled nursing facility per spell of illness. After the 20th day, coinsurance equal to 12.5 percent of the hospital deductible ($36 in 1983; $43.75 in 1984) is charged per day.

The administration proposes to restructure the Medicare Part A benefit to provide coverage for unlimited hospital days. The existing deductible applicable to the first day of hospital care would remain in place. Cost-sharing requirements would be revised by imposing coinsurance equal to 8 percent of the deductible (about $28 in 1984) on days 2 through 15 of a spell of illness. After day 15, the coinsurance amount would drop to 5 percent ($17.50). After the 60th day, no beneficiary would be required to pay either a coinsurance or a deductible (catastrophic cap). The coinsurance rate for days 21 through 100 of care in a skilled nursing facility would be reduced from 12.5 percent to 5 percent of the hospital deductible.

The AHA supports the intent of the Administration's Part A restructuring, and views this as an important first step in approaching the demand side of the health care equation by creating more cost consciousness on the part of the beneficiary. Moreover, by providing catastrophic protection, the proposal would remove the financial burden—and the fear of devastating costs—for the most seriously-ill beneficiaries.

For consumers, changes in cost sharing should stimulate more careful use of health care services and selection of providers. However, when options for beneficiary cost sharing are being considered, the AHA believes the following guidelines should be followed: First, consumer cost sharing should promote cost consciousness in the decision to choose inpatient hospital care or a less costly alternative, such as outpatient treatment. Second, cost sharing should be predictable, so that consumers are aware of any out-of-pocket liability at the time decisions on provider and service are made. Third, it should be equitable, so that consumers are not denied access, and seriously-ill patients who require intensive care do not experience undue financial burdens. Fourth, it should be simple, as well as easy to understand and administer, so that consumers are not confused and administrative costs increased.

We would now like to bring to your attention several issues regarding the Administration's cost-sharing proposal which we believe deserve serious consideration.

The prospective-payment legislation recently enacted through the Social Security Amendments of 1983 (P.L. 98-21) moved away from retrospective cost-based reimbursement as the basis of hospital payment for Medicare. The prospective payment system adopted by the Congress will set prices according to diagnostic-related groups (DRGs), sever the traditional relationship between Medicare payment and costs, and put the hospital "at risk" for differences between its costs and the DRG prices. We believe that any restructuring of the Part A benefit must consider the design of prospective payment as the basis for that restructuring.

First, the existing cost-sharing benefit and the Administration's proposed cost sharing continue to be based on the per-diem cost of a hospital day of care. Since we are moving to a pricing structure for Medicare through the prospective payment system, the AHA believes it would be more appropriate to relate beneficiary cost sharing to the price, perhaps as a percentage of the DRG price.

Second, under the Administration's cost sharing proposal, all benefifiaries would pay by the same amount of out-of-pocket expenses. Because of the equal payment, beneficiaries would be, at best, financially indifferent to choosing a less costly hospital. Such a benefit design, therefore, would offer the beneficiary no financial incentive to utilize a lower-priced hospital. One way to stimulate use of lower-priced hospitals would be to base cost-sharing on a percentage of the DRG price. This way, beneficiaries could shop for the lower-priced hospital in order to pay less cost-sharing.

Also, under some circumstances such as short lengths-of-stay, the amount of cost sharing under the Administration's proposal could be more than the hospital's price for the service. This would result in a beneficiary's out-of-pocket expense being higher than the hospital's price. We believe such a situation would be inequitable to beneficiaries and recommend that provisions be included in any cost-sharing proposal to prevent this occurrence.

Third, designing cost sharing to encourage beneficiaries to seek early discharge may be unnecessary. The prospective-payment legislation itself provides strong incentives to hospitals to discharge patients as early as medically feasible. Failure to do so will place the hospital at financial risk, since the cost of additional days care beyond the DRG price will not be paid. Therefore, hospitals and attending physicians will have the incentive to shorten lengths-of-stay.

Fourth, the Administration would remove the limit on the number of days of hospitilization covered by Medicare during a spell of illness. In addition, the proposal would require no more than two inpatient deductibles during any calendar year, even if there were three or more spells of illness in that year. We agree with the Administration's intent to separate cost sharing from the spell-of-illness criteria. Cost sharing applied to spells of illness has proven to be the administrative burden to the beneficiary, the hospital, and the federal government because each time a beneficiary is admitted to a hospital, eligibility needs to be verified.

*Medicare voluntary voucher*

The Administration proposes to broaden the voucher provision enacted last year through the Tax Equity and Fiscal Responsibility Act by permitting beneficiaries to use their Medicare benefits to enroll in a wider range of private health plans. The proposal would require a qualified plan to be a health maintenance organization (HMO), an indemnity insurer, or a service benefit plan. All plans would be required to cover, at a minimum, Parts A and B services of Medicare, and no plan would be permitted to charge higher cost sharing than under the traditional system.

The AHA supports the broadening of the voucher proposal because it would inject more competition into the health care system by allowing beneficiaries to choose alternatives to traditional Medicare coverage. It would encourage private health insures and HMOs and other alternative forms of health care delivery systems to devise vaired ways of providing benefits and holding down costs, so they can compete for beneficiaries' business by offering coverage of additional services. And it would control Medicare expenditures by establishing a known, fixed amount that Medicare would pay toward the care of beneficiaries electing the voucher.

However, we recommend that you consider expanding the Administration's proposal to include hospitals as eligible health benefits organizations. As the centers for health care services for their communities, hospitals are uniquely qualified to plan and provide the types and range of services needed and desired by their communities.

*Access to records of subcontractors*

The Administrations proposes to amend Section 952 of the Omnibus Reconciliation Act of 1980 (P.L. 96-499). Section 952 states that in order for a provider to receive Medicare payment for services rendered under contracts with subcontractors which have an annual cost of at least $10,000, such contracts must contain a provision allowing the Secretary of HHS or the Comptroller General access to the contract and to books, documents, and records of the subcontractor to verify costs. The Administration would amend this provision to raise the cost of contracted services to $50,000.

Because the recently enacted prospective-payment legislation moves away from cost-based reimbursement to a prospective fixed price and places hospitals at risk for differences between their costs and the price, we believe that this provision is no longer necessary, appropriate, or justified. Therefore, we recommend that this section not be amended, but repealed.

*Medicare contractor initiative*

Current law permits hospitals to nominate organizations (fiscal intermediaries) to process their Medicare claims and settle their cost reports. The Administration proposes to eliminate providers' right to nominate their fiscal intermediaries, permit contracts to be based not solely on cost, and expand the Secretary's authority to experiment with alternative contracting arrangements.

The AHA opposes the elimination of a provider's right to nominate its own fiscal intermediary. The nomination process was included in the original Medicare legislation in order to ensure acceptance and smooth operation of the program. We believe that the exercise of this right not only has achieved this goal, but also continues to ensure a well-run program. Frequent changes in intermediary designation, which would result from the elimination of the nomination process, would result in the duplication of overhead and start-up costs and reduce the efficiency of program administration.

Moreover, knowledge gained from hospital-intermediary relationships has led to subtle refinements in the administration of the program. Intermediaries and hospitals have engaged in mutally beneficial educational programs, developed workable channels of communication, and begun to develop cost-saving electronic claims systems. Altering the current method of contracting would inevitably lead to major disruptions in the system. This is particularly true if contracts would be rebid on a one- or two-years cycle. Long-term relationships would be destroyed, and sophisticated software and electronic claims communications systems would be abandoned only to be recreated when a new contractor would take over.

Further, the elimination of the nomination process could lead to instability in the system, particularly in light of the recent enactment of prospective payment. The intermediary has and will continue to play a key role in interpreting and communicating decisions made by HHS on implementing the new payment system. We believe it would be poor judgment to eliminate the nomination process at a time when hospitals must work closely with their intermediaries to implement the system successfully.

Basing contracts on something other than costs may have merit, however. As with hospitals, the problem with cost-based contracts is that they provide an intermediary with little incentive to improve its operational efficiency. A prospective or fixed-price system of intermediary payment would provide such an incentive, just as does the prospective-payment incentive for hospitals. A fixed-price system would be compatible with hospital prospective payment and with the existing process of intermediary nomination.

*Eliminate waiver of liability*

This proposal would eliminate the waiver of liability afforded to an institutional provider when Medicare claims are disallowed because the care was deemed after the fact as not "medically necessary" or not a Medicare-covered item, even when the provider is totally without fault.

The AHA believes there is no reason to penalize hospitals which have made good-faith efforts to provide needed services—as ordered by physicians and other professionals. There is no evidence that hospitals have abused this waiver authority. Repealing it would only increase existing bad debts. Further, should changes in benefits occur, for example, in response to the projected deficit of the HI trust fund, the waiver of liability would serve an important function of protecting hospitals which are making good-faith efforts to provide covered services during the time the Medicare program is in transition.

*Deferment of recipient eligibility*

The Administration also proposes that eligibility for Medicare be effective the first day of the month following an individual's 65th birthday, rather than the first day of the month in which the person turns 65. The AHA has reservations about this proposal, which would save an estimated $201 million in fiscal year 1984. Because some persons who retire at 65 lose coverage under employers' health insurance plans, there could be gaps in coverage. One way in which such gaps might be filled is by requiring employers to extend their plans to the beginning of Medicare eligibility.

## MEDICAID PROPOSALS

*Reduction in Federal payments*

The Omnibus Reconciliation Act of 1981 reduced federal payments to states for the Medicaid program by 3 percent, 4 percent, and 4.5 percent in fiscal years 1982, 1983, and 1984, respectively. A state's reduction could be "offset" or lessened by meeting certain conditions, and rebates could be paid to a state if spending were less than a target amount. The Administration proposes to extend the reduction of 3 percent through 1985 and beyond, and the offsets and the incentive payments also would be extended. The AHA opposes an extended or permanent reduction in federal Medicaid payments.

Since 1981, when the Medicaid cuts were enacted, the nation has experienced a deep recession. This has both reduced state revenues and increased state burdens, not only in caring for newly unemployed persons without health insurance benefits but also for other needy persons—including needy women, children, and the elderly.

More than 30 states have reduced or severely limited their own Medicaid expenditures. Reductions in state funding have been achieved through changes in eligibility requirements, lower payments to providers, and decreases in covered services. These reductions mean that access to needed health services is threatened for the low-income population.

Moreover, a recently released GAO study mandated by the 1981 Reconciliation Act, demonstrates that the Medicaid formula has exacerbated the impact of the federal reductions in some states. The study also points out that the 1981 across-the-board reductions and incentives for reduced state spending could encourage greater program disparities among the states.

We urge you to reject permanent reductions in the federal payment, examine the disparities which result from the Medicaid formula, and consider possible formula changes before continuing any long-term reduction.

*Medicaid copayments*

The Administration would require states to impose nominal copayments on Medicaid beneficiaries. The categorically needy would be required to pay $1 per day for hospital services and $1 per visit for physician, clinic, and hospital outpatient services. The medically needy would be required to pay $2 per day for hospital services and $1.50 per day for physician, clinic, and hospital outpatient services. In addition, states would be allowed to impose nominal copayments on all eligibility groups for all services.

Although the AHA supports use of mechanisms that encourage patients to make appropriate and responsible use of health services, we question whether requiring copayments from Medicaid recipients would achieve the desired goal. Medicaid recipients have limited financial resources and might be unable to meet even the nominal copayments proposed by the Administration. As a result, some Medicaid patients might forego needed care, particularly when extended periods of service are needed, and collection of small fees, set at different levels for different types of patients, could be extremely difficult for hospitals.

Moreover, federal payments to states would be reduced by the amount of the copayments, regardless of whether or not the copayments are collectible. This could translate into reduced state payments for hospital services and other health services at a time when state Medicaid payments may be so low as to threaten access to needed health services and the availability of some services.

### SUMMARY

Mr. Chairman, the AHA views some of the Administration's Medicare and Medicaid spending reduction proposals as important first steps in reforming the health care system.

We support the intent of the Medicaid Part A restructuring proposal to encourage greater consciousness on the part of beneficiaries. The catastrophic protection provision would protect beneficiaries financially from costly and lengthy treatments. The voluntary voucher proposal has the potential of increasing private sector competition and offering beneficiaries the types of services most appropriate to their needs.

We are seriously concerned, however, about the Medicaid proposals which would make the reduction in federal payments permanent and copayments mandatory. In our view, these proposals would threaten the continued availablility of services and access to needed care by Medicaid patients.

We thank you for this opportunity to share our views. The Association and its staff will gladly assist you and members of the Committee in any way possible as you work toward resolution of these critical issues.

## STATEMENT OF MONTE MALACH, M.D., BROOKLYN, N.Y., PRESIDENT, AMERICAN SOCIETY OF INTERNAL MEDICINE, WASHINGTON, D.C., ACCOMPANIED BY ROBERT DOHERTY, DIRECTOR OF MEDICAL SERVICES AND GOVERNMENTAL AFFAIRS, AND RICHARD TRACHTMAN, GOVERNMENT AFFAIRS REPRESENTATIVE

Dr. MALACH. Senator Chafee, my name is Monte Malach, M.D. I am an internist in private practice in Brooklyn, N.Y., and clinical professor of medicine at the State University of New York. I am president of the American Society of Internal Medicine. With me is Bob Doherty, director of medical services and governmental affairs, and Richard Trachtman, government affairs representative.

I am pleased to present the views of practicing internists throughout the country on ways to reduce the costs of the medicare and medicaid programs.

Most internists see large numbers of medicare patients in their practices. In fact, according to a study funded by the Health Care Financing Administration, internists and general practitioners see more medicare beneficiaries and provide them with more services than any other types of physician. Many internists also see medicaid patients on a regular basis. Consequently, the following recommendations are based on the perspectives of physicians who have a considerable amount of experience seeing medicare and medicaid patients and working with the programs' administrative requirements.

The recommendations also reflect the American Society of Internal Medicine's careful study over the last two and a half decades of the problems and opportunities facing the medical care system.

Senator CHAFEE. Why don't you proceed with the recommendations, doctor, because we don't have too much time and we want to hear your recommendations.

Dr. MALACH. Basically, our recommendations suggest incentive-based reform. And to correct the incentives, a strategy has to be developed. Specifically, the American Society of Internal Medicine advocates the following changes in the medicare and medicaid programs. One, reform the physician reimbursement system to eliminate the current bias in favor of technology-intensive procedures and against cognitive services. Under the current system, a physician who orders an expensive array of technology-intensive diagnostic services will be compensated at a high level. A physician who conducts a comprehensive history and physical examination and then makes a considered decision to send the patient home or to not utilize certain diagnostic procedures, will be paid far less.

A recent HCFA study shows that on an average, office visits are undervalued, or surgical procedures overvalued, by fourfold to fivefold. This disparity fuels the demand for high cost procedures, one of the primary causes for the rapid growth in health care costs in recent years.

From a personal perspective as a practicing physician, when a patient comes in to see me with a complaint, I might put him through a battery of tests, analyze the results, and spend very little time with him. Or I might spent an hour talking and listening to him, inquiring about family history, job situation, personal life style, and obtaining pertinent information that might narrow the need for tests to just a few. The diagnostic and therapeutic outcome may be the same from these two styles.

Senator CHAFEE. That makes a lot of sense; let's go to the next one.

Dr. MALACH. No. 2 then, Senator, is change the existing system for determining reimbursement allowances for new procedures. As a starting point for developing a technology neutral system, ASIM believes that changes should be made in the way that reimbursement allowances are determined for new procedures. New procedures are those technological procedures that are at a point where they have moved beyond the strictly developmental and experimental stages and are beginning to become more widely accepted and utilized.

Under the current reimbursement system the charges follow the fees set by those physicians who initially pioneer the procedure. Because those physicians have invested considerable time and resources, their charges are at a high level. However, as the procedure becomes more widely practiced, costs and risks of providing the service decrease. The result is that reimbursement allowances remain at artificially inflated levels years after the procedure enters the marketplace, increasing medical care costs.

ASIM believes that medicare and other third-party payors should work with the medical profession to develop mechanisms to link charges and allowances to the actual cost of providing a service.

Senator **Chafee**. Well, that makes so much sense, I cannot understand why it is not done. Just because a proposal makes sense doesn't necessarily mean it is being done. That is another good suggestion. Let's try No. 3. You are batting a thousand percent.

Dr. **Malach**. Thank you. The third is that we require increased medicare and medicaid cost sharing for inhospital services while providing expanded coverage for catastrophic illnesses. ASIM believes that if patients share in the cost of their medical care, they and their physicians will be more cost effective in the use of medical services. This belief is supported by both the experiences of practicing internists, and a growing body of research literature that supports the efficacy of cost sharing as a cost containment strategy. Because ASIM recently submitted a detailed statement to your Subcommittee on Health, I will not go into the literature on this matter.

Under the current law, medicare beneficiaries and physicians have little or no economic incentive to carefully consider the necessity of each day of hospitalization, once the $350 deductible is satisfied. Practicing internists are aware of many instances where a patient could be discharged a day earlier, or whatever, or could be treated in the physician's office or at home rather than in the more expensive hospital setting. In my own practice, it is not uncommon for the families of hospitalized elderly patients to ask me to keep the patient another day or over the weekend simply because it is convenient for them. As a result, I am sometimes compelled to keep the patient in the hospital because there is no place for the patient to go.

I have no doubt that this would be less likely to occur if the patient or the family were required to pay out of pocket some of the cost of that extra day or days.

Senator **Chafee**. Well, we had some guests in the other day that were indicating that the person would gladly stay the extra day, which might cost somebody else $300, rather than pay a $13 taxicab fare to go home, they wait instead for their husband to come by the next day. I suppose if the person had to pay that bill, he would take the taxicab. That is your suggestion anyway.

Dr. **Malach**. It is our suggestion basically that if there is an involvement by the patient or the family in the cost of medical care, they will be more attentive to what its actual value is.

Senator **Chafee**. All right. Go ahead.

Dr. **Malach**. Continuing, we recognize that many in Congress are concerned that cost sharing would impose an excessive economic burden on beneficiaries. To spread the cost more equitably and to broaden its appeal, we suggest that Congress might consider eliminating the $350 part A deductible, but increasing the per diem coinsurance required during the first 60 days of hospitalization. This option would result in improved medicare protection for the first day of hospitalization, which is now paid entirely by the beneficiary. Many beneficiaries with short hospital stays could be expected to be better off under this proposal than under current law, despite the increased per diem coinsurance requirements. At the same time it would encourage physicians and patients to consider cost benefit factors during the early days of hospitalization.

Basing the amount of increased coinsurance on beneficiaries' income is another suggestion. This would insure that economically disadvantaged individuals are not unduly penalized by coinsurance requirements. The CBO has reported that this option, while somewhat complex, is administratively feasible.

Another option is offering a series of options under medicare with different benefit structures as suggested by the CBO in its May 1982 report. Under this proposal, medicare would offer several plans with different levels of cost sharing. Persons choosing an option less comprehensive than the current medicare benefit structure would get a cash payment reflecting medicare's claims experience with the option. Those selecting a more comprehensive option would pay an additional premium. The CBO believes that such a choice would increase the average degree of cost sharing, since those seeking more cost sharing, who have no opportunity to do so today, would be more likely to change plans.

For similar reasons, ASIM supports the administration's proposal to mandate modest copayments in the medicaid program. Such requirements will tend to reduce unnecessary visits to the physician or hospital emergency room, but not to the extent of creating a barrier to needed care.

I believe the preceding recommendations will do much to encourage more efficient, less costly care. Some argue that cost sharing and other proposals to influence physician and patient behavior are no longer necessary, since DRG's and prospective pricing will create sufficient incentives for efficiency. I disagree. Prospective pricing offers direct economic incentives to only one actor in the health care system: the hospital. The hospital, by itself, cannot control how many tests a physician orders or how long a patient stays, nor should it. The type and frequency of services rendered will continue to be decided primarily by the patient and the physician. Therefore, it is essential to create incentives to alter physician and patient behavior by making patients and physicians more conscious of costs and by eliminating the existing protechnology, prohospital setting reimbursement bias. ASIM does not favor extending the new medicare prospective pricing system to physician services. We do urge Congress and the Health Care Financing Administration to work with the medical profession to develop reasonable proposals to make the medicare system of reimbursement for physician services a technology-neutral one.

Senator, we have other recommendations, but because of the shortage of time, they are enclosed in the written statement. But they do involve our recommendations on the proposed temporary freeze under the medicare economic index, which we support. We also support competitive billing for non-physician services, provided there are safeguards regarding access and quality assurance.

Senator CHAFEE. Well, thank you very much, Dr. Malach. Those are good, specific recommendations which we appreciate. It will be very helpful. I thank you also, Mr. Owen.

Now, there is a vote. I will run over and vote; why doesn't the next panel come up, Mr. Hamilton and Mr. Levitt. I will come right back.

[Whereupon, at 12:07 p.m., the hearing was recessed.]

[The prepared written statement of Dr. Malach follows:]

## TESTIMONY OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE

My name is Monte Malach, MD, and I am an internist in private practice in Brooklyn, New York and President of the American Society of Internal Medicine. With me is Robert Doherty, Director of Medical Services and Governmental Affairs and Richard Trachtman, Government Affairs Representative. I am pleased to present the views of practicing internists throughout the country on ways to reduce the costs of the Medicare and medicaid programs.

Most internists see large numbers of Medicare patients in their practices. In fact, according to a study funded by the Health Care Financing Administration (HCFA), internists and general practitioners see more Medicare beneficiaries and provide them with more services than over other types of physicians ("Analysis of Services Received Under Medicare by Specialty of Physician", Health Care Financing Review, September, 1981). Many internists also see Medicaid patients on a regular basis. Consequently, the following recommendations are based on the perspectives of physicians who have a considerable amount of experience seeing Medicare and Medicaid patients and working with the programs' administration requirements.

The recommendations also reflect ASIM's careful study over the last two-and-a-half decades of the problems and opportunities facing the medical care system. ASIM is the only national medical society dedicated exclusively to studying, and acting on, the socio-economic (as opposed to clinical) factors affecting medical care. Because of this unique background, the Society has frequently found itself in the position of advocating innovative proposals long before they are accepted by most groups within the health care arena, as well as acting as a catalyst for promoting change within the medical profession. For example, ASIM played a key role historically in encouraging the medical profession to support and participate in peer review; we were one of the first to come out in favor of national health insurance to cover the costs of catastrophic illness; and we have taken the lead in promoting reforms in the physician reimbursement system. It is in this spirit that I offer the following comments on the Medicare and Medicaid programs.

ASIM believes that an effective strategy to moderate the costs of the Medicare and Medicaid programs, while maintaining or improving the quality of care provided, must address the current reimbursement incentives built in the system that often have perverse or inappropriate results. Those incentives unintentionally reward inefficiency and penalize efficiency; encourage hospitalization, instead of care in less expensive settings; promote costly technical and surgical procedures instead of less costly, and frequently more effective, personalized caring and preventive services; and discourage patients, physicians and hospitals from becoming actively involved in holding down health care costs.

### RECOMMENDATIONS FOR INCENTIVE-BASED REFORM

To correct those incentives, a strategy must be developed to keep patients out of the hospital, to reward physicians for deciding not to use expensive technology, and to provide economic incentives for physicians and patients to more carefully consider the need for medical services.

Specifically, ASIM advocates the following changes in the Medicare and Medicaid programs:

1. *Reform the physician reimbursement system to eliminate the current bias in favor of technology-intensive procedures and against cognitive services.*—Under the current system, a physician who orders an expensive array of technology-intensive diagnostic services will be compensated at a high level. A physician who conducts a detailed patient interview, and then makes a considered decision to send the patient home or to not utilize certain diagnostic procedures, will be paid far less. A recent study funded by HCFA shows that on average office visits are undervalued (or surgical procedures overvalued) by four- to five-fold under current Medicare allowances ("Toward Developing a Relative Value Scale for Medical and Surgical Services", Health Care Financing Review, Fall, 1979). This disparity fuels the demand for high cost procedures—one of the primary causes for the rapid growth in health care costs in recent years.

From a personal perspective, I know that when a patient comes to me with a complaint, I might send him through a battery of tests, analyze the results, and spend very little time with him. Or I might spend an hour talking with him, inquiring about his family health history, job situation, personal life and so forth, obtaining pertinent information that might narrow the need for tests to a few. The diagnostic outcome may be the same from these two styles of practice. The first is expensive, and is encouraged by reimbursement incentives; the second approach could save health-care dollars and probably increase patient satisfaction (a major criticism of physicians being that they don't really listen to their patients).

The Society believes that Congress should express its intent that DHHS participate in the development of alternative reimbursement systems that would pay relatively more reimbursement for physicians' cognitive (non-procedural) services, and relatively less for surgical and technological procedures. ASIM strongly believes that a new system for determining allowances—one that eliminates the current technology intensive bias—will result in major cost savings, by not penalizing physicians who elect not to perform high cost procedures.

2. *Change the existing system for determining reimbursement allowances for new procedures.*—As a starting point for developing a "technology neutral" system, ASIM believes that changes should be made in the way that reimbursement allowances are determined for new procedures. New procedures are those technological procedures that are at the point where they have moved beyond the strictly developmental and experimental stages and are beginning to become more widely accepted and utilized by larger numbers of patients and physicians. Under the current reimbursement system, the charges for new procedures generally follow the fees set by those physicians who initially pioneer the procedure. Because those physicians have invested considerable time and resources in developing and performing the procedure, their charges appropriately are set at a level that reflects the high costs and risks required to provide the service. However, as the procedure becomes more widely practiced, the costs and risks of providing the service generally decrease.

Unfortunately, even as the costs decrease, the prevailing charges usually remain at the initially high level established by those physicians who first pioneered the procedure.

The result is that reimbursement allowances remain at artificially inflated levels years after the procedure enters the marketplace. ASIM believes that Medicare and other third party payors should work with the medical profession to develop mechanisms to more closely link charges and allowances with the actual cost of performing a new procedure. One way to do this would be for insurance carriers to establish local committees with representatives of physicians, third party payors, and others with appropriate expertise that would be charged with identifying the costs and risks involved in the new procedure and recommending an appropriate level of allowances. These committees could meet on an annual basis to review changes in the costs and risks involved in performing the procedure and to update the recommended allowances accordingly. If, in the opinion of the committee, the costs had decreased, then a lower level of allowances would be appropriate.

This type of system potentially can result in considerable savings for patients, as well as for Medicare and other third party payors. For the first time, reimbursement allowances will be linked directly to the cost of providing a service. Instead of constant increases in prevailing charges, allowances would gradually decrease. Each time the procedure is performed in subsequent years, Medicare, Medicaid and other third party payors would save money over what would now be paid under the current reimbursement system.

ASIM would welcome the opportunity to work with Congress and HCFA to fully develop this and other proposals to eliminate the existing pro-technology bias in the reimbursement system.

3. *Require increased Medicare and Medicaid cost sharing for in-hospital services while providing expanded coverage for catastrophic illnesses.*—ASIM believes that if patients share in the cost of their medical care, they and their physicians will be more cost effective in the use of medical services. This belief is supported by both the experiences of practicing internists, and the growing body of research literature that supports the efficacy of cost-sharing as a cost containment strategy. Because ASIM recently submitted a detailed statement on cost-sharing to your Subcommittee on Health, I will not at this time cite the relevant research literature, but instead address the subject from my perspective as a practicing internist.

Under current law, Medicare beneficiaries and physicians have little or no economic incentive to carefully consider the necessity of each day of hospitalization, once the $350 deductible is satisfied. Practicing internists are aware of many instances where patients could be discharged from the hospital a day earlier, or could be treated in the physician's office or at home rather than in the more expensive hospital setting. In my own practice, it is not uncommon for the families of hospitalized elderly patients to ask me to keep the patient in the hospital "one more day," simply because it is inconvenient for them to take the patient home. As a result, I am sometimes compelled to keep the patient in the hospital longer than is absolutely necessary because there is no place for the patient to go. I have no doubt that this would be less likely to occur if the patient or the patient's family is required to pay out of pocket, some of the cost of that extra day. In the long run, considerable cost savings for the Medicare program would result from requiring beneficiaries to share the costs of the first sixty days of hospitalization.

ASIM recognizes that many in Congress are concerned that increased cost sharing will impose an excessive economic burden on beneficiaries. To spread the cost burden more eqitably and to broaden its appeal, Congress might consider:

Eliminating or reducing the $350 Part A deductible, but increasing the amount of per diem coinsurance required during the first 60 days of hospitalization. This option would result in improved Medicare protection for the first day of hospitalization, which is now paid entirely by the beneficiary. Many beneficiaries with short hospital stays could be expected to be better off under this proposal than under current law, despite the increased per diem coinsurance requirements, while at the same time it would encourage physicians and patients to consider cost benefit factors at the early days of hospitalization.

Basing the amount of increased coinsurance on beneficiaries' income. This would ensure that economically disadvantaged individuals are not unduly penalized by coinsurance requirements. The Congressional Budget Office has reported that this option, while somewhat complex, is administratively feasible (Containing Medical Care Costs Through Market Forces, May, 1982).

Offering a series of options under Medicare with different benefit structures, as suggested by the CBO in the May, 1982 report cited previously. Under this proposal, Medicare itself would offer several plans with different levels of cost sharing. Persons choosing an option less comprehensive than the current Medicare benefit structure would get a cash payment reflecting Medicare's claims experience with the option. Those selecting a more comprehensive option would pay an additional premium. The CBO believes that such a choice would probably increase the average degree of cost sharing, since those seeking more cost sharing, who have no opportunity to do so today, would be more likely to change plans.

For similar reasons, ASIM supports the Administration's proposal to mandate modest co-payments in the Medicaid program. Such requirements will tend to reduce unnecessary patient visits to the physician or hospital emergency room, but not to the extent of creating a barrier to needed care.

The preceding recommendations, I believe, will do much to encourage more efficient, less costly care. Some argue that cost sharing and other proposals to influence physician and patient behavior are no longer necessary, since DRGs and prospective pricing will create sufficient incentives for efficiency. I disagree. Prospective pricing offers direct economic incentives to only one actor in the health care system: the hospital. But the hospital, by itself, cannot control how many tests a physician orders or how long a patient stays in the hosptial—nor should it. The type and frequency of services rendered will continue to be decided primarily by the patient and the physician. Therefore, it is essential to create incentives to alter physician and patient behavior—by making patients and physicians more conscious of costs and by eliminating the existing pro-hospital setting reimbursement bias. I urge Congress and the Health Care Financing Administration to work with the medical profession to develop reasonable proposals to make this possible.

## OTHER RECOMMENDATIONS

The Society recognizes that many of our proposed structural reforms in the Medicare and Medicaid programs may not bring about immeidate cost-savings. For this reason, ASIM supports some of the Administration's proposals designed to bring about short-term savings.

Specifically, ASIM favors a one-year, temporary freeze in the Medicare Economic Index. In previous testimony and statements, ASIM has called for repeal of the economic index. We continue to believe that the index does not accurately reflect physicians' actual overhead costs and that repeal is merited.

However, in view of the current economic climate, the need to reduce federal budget expenditures, and the importance of fairly and equitably spreading the burden of budget cuts, ASIM supports a temporary freeze in the economic index for one year or less. To our knowledge, we are the only medical organization that has taken this position. Nevertheless, it is our belief that at a time when all citizens are being asked to sacrifice, physicians must also do their share and voluntarily accept relatively less reimbursement for some services. To assure that the shortfall in reimbursement resulting from the temporary freeze is not passed on to beneficiaries, ASIM has urged our members to be sensitive to the economic situation of their patients in responding to the temporary freeze.

ASIM does not, however, support the Senate Budget Committee recommendation to freeze the economic index only for those physicians who do not accept assignment. We do not believe that this proposal will increase acceptance of assignment. Instead, it will penalize those patients of physicians who (by definition) do not now accept assignment, by increasing the gap between actual charges and Medicare reimbursement, while offering no added benefit to those physicians who do accept assignment. Since we recognize that the whole issue of assignment is of interest to many in Congress, ASIM would welcome the opportunity to testify at a later date on this subject.

Finally, ASIM favors the Administration's proposal to expand DHHS's competitive bidding authority for non-physicians services, provided that there are safeguards to protect access and quality. In previous statements, ASIM has expressed concern about the effects on quality and availability of care that could result from competitive bidding for laboratory services. However, we recognize that the current economic climate necessitates implementation of procedures designed to reduce the cost of non-physician services, particularly laboratory services, except in situations where it creates access and quality problems. If Congress decides to expand the Secretary's authority to use more competitive approaches for obtaining non-physician services and supplies, language should be included requiring DHHS to monitor the effects of competitive bidding on access and quality, and to report back to Congress annually with its findings. If the findings show that the access and quality of care available to beneficiaries has been diminished due to this expanded authority, Congress should reconsider the wisdom of maintaining the proposed authority.

In conclusion, ASIM urges Congress to enact the preceding cost-saving recommendations for Medicare and Medicaid, along with other system-wide reforms—such as a limit on the tax deductibility of contributions to health insurance plans and mandated standard benefits—designed to slow the rise in expenditures on health. We offer our assistance to the Senate Finance Committee in designing and promoting such incentive-based reforms.

### AFTER RECESS

Senator **Chafee**. Mr. Hamilton, why don't you proceed?

## STATEMENT OF MIKE HAMILTON, PRESIDENT, HAMILTON OXYGEN SERVICE, BIRMINGHAM, ALA., AND PRESIDENT, NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS, ALEXANDRIA, VA., ACCOMPANIED BY CRAIG JEFFRIES, ESQ., NAMES DIRECTOR OF GOVERNMENT RELATIONS, AND FRANK CASE, ESQ., NAMES GENERAL COUNSEL

Mr. **Hamilton**. Thank you, sir. My name is Mike Hamilton. I am president of the National Association of Medical Equipment Suppliers, which we call NAMES for short. NAMES is comprised of some 1,000 businesses, most of them very small, who provide home medical equipment to what we estimate to be over 2 million patients last year. Our industry is heavily oriented toward service. We provide medical equipment that is suitable for use at home when and where it is needed, and include the necessary instructions to the patient or members of his family or household for appropriate use and the maintenance that is necessary to make the equipment useful. We feel that without that sort of service, there is no point in providing the equipment.

Our purpose in testifying today is to express some concerns about certain sections of the administration's spending reduction proposal that we are convinced would result in the elimination of a considerable number of businesses in our industry, and would actually end up reducing competition. We also have some things that we want to support, including uniform reimbursement for medical equipment, regardless of the source of supply, that is, payment at the same rate.

Senator CHAFEE. Why don't you start with the recommendations.

Mr. HAMILTON. All right, sir. We recommend that this committee not support the administration's proposal to enter into what is described as competitive bidding for medical equipment. We believe that is an unworkable solution to any problem of cost containment for a number of reasons. And I would be glad to go into any detail you like, but, basically, we feel that the proposed is unworkable unless the Government intends to get into the service business. That is, would HCFA actually buy medical equipment and warehouse, deliver it and maintain it? Advertising for bids for supplies of this sort in an area, and given the condition of our industry, would result in putting a number of small businesses out of this business, and it leaves the government at the mercy of the surviving suppliers in a very short period of time. On the other hand, if the Government tried to deal directly with the manufacturers of medical equipment that could be used at home, then it would be a cumbersome process. It would be next to impossible for the Government to benefit by and get into the service business and actually replacing the DME industry.

We feel that the result over a very short period of time of implementing the competitive bidding proposal would be disastrous to the industry and would practically remove the DME benefit from the medicare program. Mr. Chairman there are a number of indications that we already have a very competitive industry. The pricing methodology that is currently used to determine what is paid to our industry for services that we furnish to medicare beneficiaries contains a number of measures that result in competition in our industry already. And there are some other things that might result in improving competition, but eliminating a number of companies in the business is certainly not one of them.

The competitive bidding proposal is also against the tradition of Congress, which has recommended very specifically how programs affecting health care delivery system would be operated. This proposal would give the Secretary and the Health Care Financing Administration a very broad range of authority to write almost any sort of regulations that they would like. We are not clear at all on what their intentions are. NAMES would be in a better position to comment on some of the potential problems if we knew exactly how NCFA proposes to implement the proposal.

We support and ask your support for the adoption of section 104 of S. 643, which would improve competition, in fact, instead of in name only like section 112, by requiring that a 20-percent copayment be made by beneficiaries obtaining medical equipment for home use, regardless of the source of supply. We believe that adopting section 104 would serve to discourage overutilization and would result in increased competition and in lower costs to the Government.

NAMES is also very concerned about the issue of excessive or prolonged rentals for medical equipment. There are studies the Government has either conducted or contracted, including the Williams College study, which we will submit to you with our written testimony, and a GAO report of July of 1982, that indicate that changes that have been proposed pursuant to a law—Public Law 95-142, section 16—which has been referred to for a long time as the lease/purchase law should not be implemented. In part, regulations should not be implemented and the law changed based on the information from the Williams College study and the GAO report, because the indications of both of those organizations are that the Health Care Financing Administration could increase costs considerably by making these changes.

The General Accounting Office has undertaken a study for updating figures that were used in some of these past reports, and will have a report available in a fairly short period of time. We feel very strongly that it would be in the best interest of the program to delay implementing any changes in regulations until the results of that complete study are known and compared with the Williams College study. The preliminary indications are that it will be a very costly mistake to make. NAMES is working with your staff and other government officials to come up with an alternative, more suitable proposal that will put that issue to rest forever. That is, the issue of what may be problem rentals, to determine what actually would be the least expensive method of obtaining this equipment for the Government in a manner that would be acceptable to industry carriers, and beneficiaries.

Thank you, Mr. Chairman. Are there any questions.

Senator CHAFEE. Fine, thank you, Mr. Hamilton.

Mr. HAMILTON. Thank you, sir.

Senator CHAFEE. Mr. Wasserott.

[The prepared written statement of Mr. Hamilton follows:]

### STATEMENT OF NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS (NAMES) PRESENTED BY MIKE HAMILTON, PRESIDENT OF HAMILTON OXYGEN SERVICE, PRESIDENT OF NAMES

Mr. Chairman, members of the committee, my name is Mike Hamilton. I am President of Hamilton Oxygen Service, Birmingham, Alabama and President of the National Association of Medical Equipment Suppliers (NAMES). NAMES is a national trade association representing suppliers of durable medical equipment (DME) for use in the home. In 1982, we estimated that NAMES 1000 members supplied medical equipment to over two million patients in their homes throughout the United States.

Most NAMES members are small businesses serving local communities or small geographic areas. They work closely with physicians, hospital discharge planners, therapists, nurses and the patient's family to provide quality medical products and services at reasonable and competitive prices. The DME industry is heavily oriented toward service. NAMES estimates that the typical DME supplier spends less than 35 percent of their total cost of doing business on the purchase of equipment and approximately 50 percent of the cost of doing business on service related expenses.

For example, most NAMES members who deliver and maintain respiratory equipment provide monthly house calls by a respiratory therapist or other trained employee. This individual checks the equipment, sees if the patient is following the doctor's orders and answers any question the patient or their family may have. Patients and their family often develop a very close relationship with the supplier.

#### MEDICARE SPENDING REDUCTION PROPOSALS

Mr. Chairman, our purpose in testifying today is to express concern about certain sections of the Administration's HCFA spending reduction proposal which would eliminate many DME businesses and reduce competition, express our support for uniform reimbursement for DME whether the equipment is supplied by a home health agency or a DME supplier and also to reassert the need to focus Congressional attention on appropriate, reasonable and cost effective legislation that addresses the real issue behind the Medicare DME rent/purchase issue—the issue of excessive rental.

### THE ANTICOMPETITION PROPOSAL

Section 113 of S. 643 would give HCFA "carte blanche" authority to rewrite the Medicare reimbursement system for DME suppliers and others by giving HCFA the authority to create "exclusive agreements and negotiated rates for certain medical and other health services" thus taking away the beneficiary's freedom to select the supplier of their choice.

Section 113 has been euphemistically referred to as the "competitive bid" proposal, thus giving it a certain degree of legitamacy. However, the facts are that Section 113 would *reduce* competition by forcing a significant percentage of DME companies out of business.

Neither Section 113 nor HCFA's summary explanation specify how HCFA intends to carry out the "exclusive agreements and negotiated rates." What is clear, is that this proposal would abrogate legislative responsibility in an area, Medicare, where Congress has traditionally created very specific programs. For example, Congress passed a very specific prospective payment law for hospitals rather than delegating that authority to HCFA.

How does HCFA propose to implement the "exclusive agreements and negotiated rates"? Does HCFA plan to enter the DME business in the capacity of a wholesale distributor or supplier? Since only 35 percent or less of the cost of maintaining a typical DME business relates to the purchase of products, will the government absorb the other 65 percent or more of the business costs by simply eliminating necessary services to Medicare beneficiaries? Would HCFA warehouse the product, set it up, service it on a regular basis, deliver and pick it up, educate beneficiaries about its use and provide 24 hour emergency service? Under this scenerio most of the existing DME businesses, 50 percent or more of whose income is derived from the Medicare program, would go out of business.

Other scenarios exist. Suppose HCFA would direct each Medicare carrier to negotiate with one or more DME suppliers in each state to supply all equipment for a given area. Those who fail to receive a contract would in many cases be forced out of business. This scenerio would eliminate competition and any possible short term cost savings to the Medicare program would be more than lost in later years due to the local monopoly created by HCFA through its "exclusive agreements and negotiated rates." Even HCFA recognizes this anti-competitive problem because the proposal specifically exempts Section 113 agreements from any law requiring either competition or the advertisement of proposals to enter into a contract with the federal government. HCFA's waiver of a law which actually promotes competition should be carefully scrutinized.

If the Administration really wants to increase competition in the already very competitive DME industry, NAMES suggests greater beneficiary involvement in choosing a DME supplier—not more government intervention.

One such proposal is embraced in H.R. 101 introduced this year by Representative Duncan (R-2nd-TN). Section 3 of H.R. 101 entitled the "Durable Medical Equipment Disclosure Amendments of 1983" would allow Medicare Part B payment to be made:

"On the basis of an assignment for the purchase or rental of durable medical equipment (including equipment servicing as authorized by the Secretary pursuant to regulations where such servicing is customarily associated with the proper functioning of the equipment) under terms of which the individual to whom such service or equipment was furnished is fully and completely informed by a written disclosure statement provided by the supplier of such equipment, receipt of which is acknowledged in writing by such individual or his representative, which clearly identifies the item of supply, equipment or equipment servicing covered by the assignment; the reasonable charge for such item; the amount of the charge, if any, in excess of the reasonable charge, together with an explanation of the reasons for such excess charge; the amount for which payment is expected to be made under this part; the amount for which payment must be made by the individual; the obligation of the supplier of such equipment not to change his charge for not less than 14 days following the date of the written acknowledgment of receipt of the disclosure statements; and which shall be in such form as shall be prescribed by the Secretary in regulations following consultation with suppliers and users of medical equipment and others interested in its use:"

In summary, NAMES urges you not to support the Administrations "exclusive agreements and negotiated rates" proposal (Section 113 of S. 643) for the following reasons:

HCFA has never demonstrated that the DME industry is not competitive and that the Medicare reimbursement rates are not reasonable.

Congress has traditionally created very specific guidance for the Medicare program, e.g., prospective payment for hospitals. The Administration's proposal would abrogate Congress' responsibility in this area.

The "exclusive agreements and negotiated rates" proposal is too vague to warrant serious consideration. It is unclear how HCFA would carry out their authority under this proposal and how HCFA calculated the proposed savings.

This proposal would eliminate a Medicare beneficiary's freedom of choice to select a DME supplier. HCFA would choose a supplier. This would place a greater administrative burden and expense upon HCFA to supply the DME benefit and select a supplier.

Mr. Chairman, members of the Committee, please let unfettered competition determine which small businesses survive—not government policies which are competitive in name only.

### ELIMINATE THE UNFAIR COMPETITIVE ADVANTAGE CURRENTLY ENJOYED BY HOME HEALTH AGENCIES IN RENTING OR SELLING

Adoption of Section 104 of S. 643 would increase competition in the sale or rental of DME and ensure uniform reimbursement for DME furnished to a beneficiary in his home regardless of whether the equipment was supplied by a hospital based or free-standing home health agency or DME supplier. Currently home health agencies have an unfair competitive advantage because the Medicare beneficiary is not currently required to pay the $75 deductible and 20 percent coinsurance which the DME supplier must collect from the beneficiary for the same equipment. Thus, the most important component of free market competition, price, is not a factor in the beneficiary's selection of an equipment supplier.

If this proposal is accepted HCFA estimates cost savings to the Medicare program of $15 million for 1984 and 1985; $20 million for 1986 and 1987 and $25 million for 1988. NAMES urges you to support Section 104 thus interjecting real competition in the sale or rental of DME.

NAMES is as concerned as the critics of Section 104 are with the possibility of Medicare beneficiaries being unable to obtain necessary equipment without 100% reimbursement. However, the durable medical equipment industry and Medicare beneficiaries have lived with coinsurance for DME under Part B for over 15 years, and found that beneficiaries have private insurance, Medicaid, other state aid or family support to assist in paying the coinsurance amount.

Another problem of unfair competition is not addressed by S. 643 or the spending reduction proposals. Many hospitals and some home health agencies are expanding their operations into all facets of home health, including DME under Part B. The DME industry welcomes competition provided it is fair and based on the traditional concepts of reasonable price and quality of service and care. However, competition is often short circuited as hospitals and home health agencies refer their home care patients directly to hospital owned DME companies. This control over the patient when a need for DDE develops is both unfair and improper. It impedes competition by not providing the opportunity for patients, their family or physician to determine if better medical equipment can be found which is lower priced or of superior quality or if an equipment supplier exists which can provide a better service or more professional expertise.

NAMES urges this committee to conduct a study of unfair competition resulting from hospital or home health agency capture of the referral of patients to DME suppliers they control. NAMES pledges their support to assist in this policy evaluation.

### RENT PURCHASE AND EXCESSIVE RENTAL

In 1977, Congress passed Public Law 95-142. Section 16 gave the Secretary of Health and Human Services the authority to determine if the expected duration of medical need for the equipment warranted the presumption that purchasee of the equipment would be less costly or more practical than rental. Section 16 also directed the Secretary to encourage DME suppliers to make their equipment available on a lease-purchase basis whenever possible.

As HCFA sought to implement Section 16 they expaneded the scope of the statute into other areas, e.g., warranties; assumed from the beginning that there was a presumption of cost savings for purchase rather than rental of medical equipment, and ignored their own studies and facts presented by the industry regarding problems for beneficiaries, carriers and suppliers. Because of the problems and controversies, the regulations and guidelines have yet to be implemented. To help resolve the problems HCFA awarded a three year, $600,000 grant to Williams College to evaluate the cost effectiveness of various alternative reimbursement policies for DME.

HCFA's Williams College final report has been issued. It concludes that "under reasonable assumptions concerning the administrative costs of making the purchase/rental determination, the carrier error rate, and the incidence of delayed purchase, DME reimbursement expenditures under the new regulation will be higher than under the previous regulations". A copy of the full report is submitted for the record. Despite the HCFA Williams College study, and other criticisms from Medicare carriers, beneficiaries, and DME suppliers, and the current review by the General Accounting Office, HCFA has continued to allocate energy and scarce resources to implementation of the regulations and guidelines.

Mr. Chairman, Members of the Committee, it is time to again address the narrow issue that resulted in the enactment of Section 16 of P.L. 95-142. The issue at that time was the singular problem of excessive rental of DME. With mounting certainty as we await GAO's analysis, Section 16 is seen as legislative overkill. Senator Heinz, in recognition that Section 16 addressed a minor problem with overkill, has called for its repeal by introducing S. 1302. NAMES urges all Committee members to support Senator Heinz's measure as a first step to having the DME industry, carriers, beneficiaries and the government develop a workable solution to the problem of excessive rental, if such problem exists.

Mr. Chairman, thank you for this opportunity to present our comments.

## STATEMENT OF PAUL WASSEROTT, JR., PRESIDENT, WASSEROTT, INC., KINGSTON, PA., AND PAST PRESIDENT, HOME HEALTH GROUP, HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION, WASHINGTON, D.C., ACCOMPANIED BY ROBERT WILBUR, DIRECTOR OF GOVERNMENT RELATIONS, HEALTH INDUSTRIES DISTRIBUTORS, AND JAMES CROSS, ASSISTANT DIRECTOR OF GOVERNMENTAL RELATIONS, HIDA

Mr. WASSEROTT. Mr. Chairman, the Health Industry Distributors Association represents over 500 firms who supply medical equipment to hospitals, nursing homes, industrial users, and patients in the home-care environment. Approximately half of our members provide durable medical equipment and oxygen for use in the home. I am a supplier of oxygen and DME in western Pennsylvania, and the former chairman of our association's home health care group.

With me are Robert Wilbur, our vice president of government relations for HIDA, and James Cross, the assistant director.

The adoption of prospective payment and the competition which would now occur among providers marks the beginning of a major process of changes in the provision of health care in our country. We expect some part of the total national patient care to now shift from the hospitals to the ambulatory surgical center, to the home, or to other facilities. We believe policies should encourage the use of lower cost facilities when they can provide proper patient care. If earlier discharge from hospitals is to occur, proper reimbursement for services and supplies provided in the home must be in place. I would like to address briefly three issues at this time. One, the administration's proposal for authority for competitive purchase of durable medical equipment; the requirements for payments of coinsurance for durable medical equipment: and pending regulations which would require purchase, rather than rental, of DME in some circumstances.

First, competitive purchase. The administration has asked to be allowed to purchase durable medical equipment and other suuplies in bulk so as to take advantage of the savings which might be generated. We have asked repeatedly to meet with HCFA to find out better how they believe they might purchase equipment in bulk and at the same time provide the services, including deliveries and maintenance, which are essential for a home use of medical equipment. So far they have not met with us and have not provided any additional information.

If the administration's concept is to negotiate with only one or two suppliers in each locality, other practical problems emerge. First, the industry is so diverse and so competitive that no one supplier is large enough to handle all the businesses in any one area, even if he were guaranteed a monopoly. Second, if this did occur, the deliberate creation of an allogopoly of surviving suppliers would destroy the very competition which the administration should rely on to control costs.

If one supplier got all the business in one area, how long would the Government enjoy low costs from that supplier? The States already have authority to negotiate competitive or bulk purchasing contracts under medicaid. States appear to have moved very slowly to attempt to implement this probably because they see the practical difficulties.

We would suggest that the administration not be given this authority, at least until the States have been given more time to develop pilot projects and report on their experience.

Second, we support the recommendation that all parties who would provide equipment for home use should charge the same coinsurance. These provisions were originally put in the law to prevent overutilization. If no coinsurance is required, the equipment may sometimes remain in the home even when no longer needed. Further, if one group of suppliers charges coinsurance while another does not, there is an incentive to the beneficiary to obtain equipment from the supplier who does not charge coinsurance, even if his are not the lowest prices.

Third, I believe you are familiar with the issue over whether the Government would reduce expenditures through purchases rather than rental of durable medical equipment We had previously recommended to the Health Care Financing Administration that all less expensive items always be purchased rather than rented; that a decision be made after 5 months for other items; and that the reasonable charge screens for purchased equipment be revised and updated. This would prevent hardship to beneficiaries who would have to pay the difference between the reasonable charge and the actual charge where the charge for screens are so low that the supplier cannot take assignment.

Last year, a study for HCFA cast doubt on the belief that initial purchase of low priced equipment would reduce medicare expenses. A preliminary report by the General Accounting Office, which may resolve this issue, says, "We have therefore temporarily withdrawn our recommendation on this part of the issue." Depending on the GAO report, we may wish to revise our recommendations or develop recommendations to you for further amendment of the study.

We remain very concerned that the reasonable charge level for purchased equipment are, in many localities, unreasonably low. In extreme cases, the allowed reimbursement is actually less than the supplier's wholesale replacement cost. In other cases, the reasonable charge is based on sales by firms which provide no delivery, no set up, or no patient instructions. If the regulation is put into effect, we believe HCFA must instruct the carriers to establish new reasonable charge screens.

Thank you for this opportunity to discuss these issues. We look forward to continue working with you and your staff with this committee as we have in the past.

Senator Chafee. Well, gentlemen, thank you very much for your testimony. We appreciate it.

Now there is a study coming out on this, isn't there?

Mr. Wasserott. Yes, sir.

Senator Chafee. The GAO. We will look forward to seeing that, and we will be working with you as we go ahead.

Mr. Wasserott. Thank you, sir.

Senator, may I ask you just one more thing?

Senator Chafee. Sure.

Mr. Wasserott. I forgot to introduce Mr. Frank Case of the law firm of Case & Cohn, our general counsel, and Mr. Craig Jefferies, our director of government affairs for NAMES, who are with me. We have been informed that some HCFA officials, some people from the Department of Health and Human Services will be here tomorrow, and we wonder if we might be allowed the opportunity to respond for the record to the testimony that they issue tomorrow.

Senator Chafee. Sure.

Mr. Wasserott. All right. Thank you very much.

Senator Chafee. Thank you very much, gentlemen. That concludes the hearing for today.

[The prepared written statement of Mr. Wasserott follows:]

## REMARKS BY PAUL WASSEROTT, JR., PRESIDENT, WASSEROTT'S, INC., ON BEHALF OF THE HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION

Mr. Chairman, the Health Industry Distributors Association represents over 500 firms which supply medical equipment to hospitals, nursing homes, Industrial users, and to patients for home care. Approximately half of our members provide durable medical equipment and oxygen for use in the home. I am a supplier of oxygen and DME in Western Pennsylvania and former chairman of the Association's home health care group. With me are Robert Wilbur, Vice President of Government Relation for HIDA, and James Cross, Assistant Director.

The adoption of prospective payment and the competition which will now occur among providers marks the beginning of a major process of change in the provision of health care in our country. We expect some part of total national patient care to now shift from the hospital to the ambulatory surgical center, to the home, or to other facilities. We believe policies should encourage the use of lower cost facilities when they can provide proper patient care. If earlier discharge from hospitals is to occur, proper reimbursement for services and suppliers provided in the home must be in place.

I would like to address briefly three issues at this time: the Administration proposal for authority for "competitive" purchase of durable medical equipment; the requirement for payment of coinsurance for durable medical equipment; and pending regulations which would require purchase rather than rental of DME in some circumstances.

First, "Competitive" purchasing. The Administration has asked to be allowed to purchase durable medical equipment and other supplies in bulk, so as to take advantage of savings which might be generated. We have asked repeatedly to meet with HCFA to find out better how they believe they might purchase equipment in bulk and at the same time provide the services, including delivery, set-up, and maintenance, which are essential for the home use of medical equipment. So far, they have not met with us and have not provided any additional information.

If the Administration's concept is to negotiate with only one or two suppliers in each locality, other practical problems emerge. First, the industry is so diverse and so competitive that no one supplier is large enough to handle all business in any one area even if he were guaranteed a monopoly. Second, if this did occur, the deliberate creation of an oligopoly of surviving suppliers would destroy the very competition which the Administration should rely on to control costs. If one supplier got all the business in one area, how long would the government enjoy low costs from that supplier?

The states already have authority to negotiate competitive or bulk purchasing contracts under Medicaid. States appear to have moved very slowly to attempt to implement this, probably because they see the practical difficulties. We would suggest that the Administration not be given this authority, at least until the states have been given more time to develop pilot projects and report on their experience.

Second, we support the recommendation that all parties which provide equipment for home use should charge the same co-insurance. These provisons were originally put in the law to prevent over-utilization. If no co-insurance is required, equipment may sometimes remain in the home even when no longer needed. Further, if one group of suppliers charges co-insurance while another does not, there is an incentive for the beneficiary to obtain equipment from the supplier who does not charge co-insurance, even if his are not the lowest prices.

Third, I believe you are familiar with the issue over whether the government would reduce expenditures through purchase rather than rental of durable medical equipment. We had previously recommended to the Health Care Financing Administration that all less expensive items always be purchased rather than rented; that a decision be made after five months for other items; and that the "reasonable" charge screens for purchased equipment be revised and updated. This would prevent hardship to beneficiaries who would have to pay the difference between the reasonable charge and the actual charge where the charge screens are so low that the supplier cannot take assignment.

Last year, a study for HCFA cast doubt on the belief that initial purchase of low-priced equipment would reduce Medicare expenditures. Pending a report by the General Accounting Office, which may resolve this issue, we have therefore temporarily withdrawn our recommendation on this part of the issue. Depending on the GAO report, we may wish to revise our recommendations or develop recommendations to you for further amendment of the statute. We remain very concerned that the "reasonable" charge levels for purchased equipment are, in many localities, unreasonably low. In extreme cases the allowed reimbursement is actually less than the supplier's wholesale replacement cost. In other cases, the reasonable charge is based on sales by firms which provide no delivery, set-up, or patient instruction. If the regulation is put into effect, we believe HCFA must instruct the carriers to establish new reasonable charge screens.

Thank you for the opportunity to discuss these issues. We look forward to continuing to work with you and the staff of this committee, as we have in the past.

[Whereupon, at 12:37 p.m., the hearing was concluded.]

# ADMINISTRATION'S FISCAL YEAR 1984 BUDGET PROPOSALS—II

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THURSDAY, JUNE 16, 1983

U.S. SENATE,
SENATE COMMITTEE ON FINANCE,
*Washington, D.C.*

The committee met, pursuant to notice, at 10:05 a.m. in room SD-215, Dirksen Senate Office Building, Hon. Robert J. Dole (chairman) presiding.

Present: Senators Dole, Danforth, Durenberger, Symms, Long, Bentsen, and Boren.

Senator DANFORTH. Mr. Svahn is ill. Mr. Donnelly, I understand you are filling in for him.

Mr. DONNELLY. Yes, sir.

## STATEMENT OF HON. THOMAS R. DONNELLY, ASSISTANT SECRETARY FOR LEGISLATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. DONNELLY. Mr. Chairman, I do want to express the Secretary's regrets both because she could not be here, and because she had hoped the Under Secretary could appear before this committee to deal with the legislative proposals in the President's budget. Mr. Svahn is quite ill. He tried valiantly to get prepared yesterday, and we actually, under doctor's orders, sent him home. So I am here to bring you his message and hopefully respond to the committee's questions.

Accompanying me are Dr. Robert Rubin, the Assistant Secretary for Planning and Evaluation, and Dr. Carolyne Davis, the Administrator of the Health Care Financing Administration

It is a distinct pleasure to be here today, Mr. Chairman to discuss the administration's spending reduction proposals pending before your committee. I would ask that the Under Secretary's full statement be inserted for the record, and we have provided that.

As you are aware, Mr. Chairman, two crucial components of the 1984 legislative package, the social security amendments and the prospective payments to hospitals, have already been signed into law. This committee, under the capable leadership of Chairman Dole and you, Mr. Chairman, have made an important contribution in crafting this landmark legislation and facilitating its passage.

The enactment of the social security amendments has given us the opportunity to demonstrate that the administration and the Congress can work together to resolve the problems that threaten the financial soundness of the social security and medicare programs.

Now, before I review the other 1984 cost-saving proposals, I would note that at the midpoint of President Reagan's first term we have succeeded in slowing the dizzying growth rate of spending while preserving our compassionate mission.

Still, an overwhelming 96 percent of the fiscal year 1984 HHS budget consists of entitlement programs. And though some statutory changes have been enacted that affect nondiscretionary spending in the outyears, and though we have achieved some savings by careful targeting of the remaining 4 percent, we can only control entitlement growth, finally getting a grip on Federal spending and providing critical needs for program beneficiaries, by readdressing entitlement savings.

Despite our success in slowing the growth of medicare and medicaid, overall health care costs continue to climb. Without additional changes, medicare's hospital insurance trust fund will be depleted in 1990, under intermediate economic assumptions, or in 1988, under more pessimistic assumptions.

Hidden costs, unquestioned reimbursement, and the resulting absence of price competition among providers have worked to sustain the high inflation rate in health care. "Backward incentives" have contributed to rising costs, and we need to correct this trend if we are ever to get control of the problem.

The administration's health incentives reform program introduced in the Senate by Chairman Dole on March 1 will help control inflation and encourage competition in the health care marketplace. I would like to highlight its principal components:

A major component, prospective payment to hospitals, the centerpiece of this health incentives reform program, was signed into law by President Reagan on April 21. This replaces the inflationary retrospective cost-based reimbursement system for hospitals with a system that establishes hospital payment rates in advance of the delivery of care.

Another important element in our proposed reforms is the proposal to restructure medicare cost-sharing under part A. In summary, the proposal would provide beneficiaries with protection against catastrophic illness by eliminating patient cost-sharing for any hospital days of care during a calendar year after the 60th day, and it would be financed by modest increases in the deductible for stays of less than 60 days. This proposal would create incentives for savings when those incentives can work and would better protect the medicare patient needing long hospitalization.

The Medicare Voucher Act of 1983, now S. 641, would expand opportunities for medicare beneficiaries to use their health benefits to enroll in a wider array of private health plans as an alternative to traditional medicare coverage.

The Health Care Financing Amendments of 1983, S. 643, include a number of reform initiatives such as increasing the part B medicare premium in stages until the premium covers 35 percent of the estimated program costs, moving closer to that original balance between premium and general revenue financing in part B.

We would also index the part B deductible to increase with annual changes in the medicare economic index, helping to maintain the constant dollar value of the deductible.

We would delay the increase in medicare customary and prevailing charges for physician services for 1 year, as physician expenditures are the second largest component of medicare spending.

We would complement the prospective payment legislation by modifying the allowable rate of increase in hospital costs to further control the growth in hospital expenditures.

We would conform the effective date of the medicare entitlement to the effective date for receiving social security benefits for individuals who retire at age 62.

We would repeal the requirement that hospitals conduct utilization reviews of services provided, since we believe such activities can be effectively carried out by medicare intermediaries.

In the area of medicaid, we are proposing several initiatives designed to give more flexibility to States, stimulate more cost-conscious behavior, maintain incentives to moderate program growth at the State level, and improve the efficiency of program operations.

We would ask for a requirement for nominal copayments for both inpatient and outpatient services, with a State option to exempt from those copayments services to pregnant women, emergency services, and services to medically needy individuals who enrolled in HMO's. We believe that if patients share in some of these costs, they and their physicians will reduce unnecessary or marginal utilization.

We have also proposed an extension of the reductions in the Federal medicaid payments authorized by the 1981 Budget Reconciliation Act, including the offsets, at 3 percent in 1985 and beyond, with States qualifying for percentage offsets under certain conditions.

We would mandate that States require medicaid applicants to assign to the State their rights to medical support and third-party payment for medical care, thus expanding the ability of State medicaid agencies to become the payor of last resort and recover any health benefit payments due from other third party payors.

We have also proposed a tax cap, Mr. Chairman, S. 640. This key component of our health incentives reform package makes changes in the tax treatment of employer contributions to health plans. It is my understanding that this committee will hold hearings on this subject next week, and Dr. Rubin will be available at that time to meet with the committee and discuss this in more detail.

In the maternal and child health program, we are proposing a number of changes in the title V authorizing legislation to further enhance the ability of States to identify their own priorities and direct their resources to areas of greatest need. These proposals continue the block grant approach, streamlining this particular block grant to make it more in tune with others that the Department operates. Included in this are:

Eliminating the Federal set-aside of 10 to 15 percent of appropriated funds; eliminating the matching requirement, since a large number of States are voluntarily devoting State and local funds to carry out major MCH programs and Federal funds do not constitute a major funding base; and allowing State authorities to transfer up to 10 percent of MCH block grant funds to other block grants administered by the Secretary of HHS.

In the income security areas, Mr. Chairman, the administration's proposals for the aid to families with dependent children program in fiscal year 1984 build on changes enacted by Congress in the last 2 years.

Over the last 2 years, the AFDC program has been significantly improved, especially during 1981, by OBRA, in which this committee played such a key role.

When these changes were first made, critics expressed considerable skepticism about their effect on working recipients. A recent independent national study conducted by a prominent nonprofit organization, Research Triangle Institute, now provides factual information to dispel these myths. The study confirmed that:

Working recipients who lost eligibility because of the OBRA changes did not quit their jobs. The RTI study showed that only 15 percent of the recipients who were terminated were on the rolls at the end of one year, a rate which is the same or lower than the rate observed prior to OBRA. The RTI study also showed that working recipients who had lost eligibility and subsequently returned to the rolls stayed on for a shorter period of time than they had previously.

Changes in the treatment of earned income did not decrease the work effort of AFDC recipients. The RTI study showed that the same percentage of welfare recipients began working after the OBRA changes as did prior to them, in spite of the economic conditions. Also, the rate of job loss by AFDC earners was virtually identical before and after OBRA—that is, 18 percent.

OBRA changes do save money. RTI estimated State and Federal savings to be approximately $24.4 million per month 1 year later. Equally important, the changes succeeded in targeting resources to those most in need.

In summary, the changes made over the last 2 years are a significant step toward this administration's goals of restoring the AFDC program to its proper place as a temporary program of assistance for those unable to support themselves, and recognizes the budgetary constraints at all levels of government.

In the 1984 proposals in this area, several are designed to strengthen work requirements and improve the employability of recipients. This administration believes that all able-bodied individuals who request assistance should be involved in some type of work-related activity from the day they apply. We would propose that:

All applicants who are able to work be required to begin searching for employment as soon as they apply for assistance. Those who cannot find employment must actively participate in a community work experience program or a subsidized employment program. Sanctions are to be applied against individuals who voluntarily terminate their employment or reduce their hours of employment without good cause.

In determining a family's need for assistance, all sources of income available to the family are considered. parents and minor siblings living with an AFDC child should be included in the assistance unit, eliminating inequities caused when families exclude members with income from the assistance unit in order to maximize welfare benefits. This recognizes that primary responsibility for support resides within the immediate family and not with the government. SSI recipients who have a separate public benefit would continue to be excluded from the AFDC unit.

Assistance would be discontinued to an employable parent or other caretaker relative when the youngest AFDC child reaches age 16, a point at which the caretaker relative is sufficiently free from child care responsibilities to enable him or her to secure full-time employment. Let me emphasize that the child's AFDC benefits are not affected by this proposed change.

Minor caretaker relatives who are not or have never been married would be eligible for assistance only if they reside with their parents, except under limited circumstances, helping to restore parental control over their minor children and removing the possibility of minors using AFDC in order to establish economic independence.

The States would be required to adjust the portion of the AFDC grant allocated for shelter and utilities for any assistance unit sharing a houshold with others, accurately reflecting recipients actual needs and giving other household members greater incentive to contribute their fair share to household support.

In summary, Mr. Chairman, the RTI study and information from other sources have established that the changes made to the AFDC program in 1981 and 1982 have been successful in reducing welfare dependency among employable individuals and targeting assistance to those most in need. The 1984 proposals are designed to build upon that progress that we have made over the past 2 years in meeting those objectives.

In the area of child support enforcement, the proposed legislation is designed to improve State efforts to collect child support on behalf of both AFDC and non-AFDC families, changing the way the Federal Government finances the program and mandating that States use methods that are proven effective and efficient. Our proposals include:

Establishing a funding approach with a clear focus on performance, tangible recognition of superior performance, and allowing for an orderly transition through a 3-year phasein to the new means of program financing to strengthen and improve the provision of services to both AFDC and non-AFDC families. The proposal would repeal the allocation of gross AFDC collections, and substitute on a quarterly basis a deduction from total AFDC collection of the total administrative expenditures for both the AFDC and non-AFDC components. The resulting net amount would be shared between the Federal and State governments, based on each State's AFDC matching rate. A key element of this proposal is to permit a considerable amount of Federal funds to be paid to States in performance awards, based on their achievements in collections for both AFDC and non-AFDC cases.

We would require all States to include in their child support enforcement programs relatively simple and inexpensive enforcement techniques to strengthen and improve the program, such as mandatory wage assignments, State income tax offsets, and administrative or quasi-judicial procedures which have been shown through program experience, studies, and endorsement of State and local program officials to be effective and efficient methods of collecting child support.

On a nationwide basis, Mr. Chairman, there is an enormous untapped potential for increasing child support collections. Program effectiveness varies widely from State to State. In fiscal year 1982, for example, 48 States produced only 12 percent of the welfare savings. These same States, however, represented 68 percent of the total administrative expenses. Clearly, in many States there is room for improvement.

In the area of OASDI, as you know, most of the old-age, survivors, and disability insurance—or social security—portion of our budget request this year was contained in the NCSSR recommendations and incorporated in the Social Security Amendments of 1983, now Public Law 98-21. President Reagan and all of us in the administration were pleased by the work of this committee and the Congress as a whole in moving quickly, decisively, and in a nonpartisan spirit to deal with that most comprehensive and significant legislation.

The fiscal year 1984 budget reflected two legislative changes not addressed in Public Law 98-21: Disability initiatives and debt management efforts.

In the area of disability benefits, on June 7 Secretary Heckler announced several new steps that we are taking to improve the administration of the disability program, especially handling of the continuing disability reviews mandated by the 1980 legislation. We are recommending:

The permitting of a disability beneficiary who appeals an SSA decision to stop benefits because he or she is not disabled to elect to have those benefits continued until the beneficiary has had a face-to-face evidentiary hearing on the appeal. When the temporary payment provision of the Virgin Islands tax bill expires in fiscal year 1984, we recommend that it be made permanent but modified to continue benefits throughout the reconsideration process.

We recommend changing the present requirement that we review, on a pre-effectuation basis, 65 percent of favorable disability determinations, providing us with the flexibility to review whatever percentage of both favorable and unfavorable determinations would result in the best quality of decisions in the most cost-effective manner.

We look forward to working with this committee in the future on these two important changes in the disability program.

In the area of debt management, one legislative proposal contemplated is to authorize recovery of overpayments in one social security administered proqram from benefits payable under another such program. Last year the Senate adopted a provision to permit recovery of SSI overpayments from future OASDI benefits, which substantially incorporated the proposal that we are considering, but the provision was not agreed to in conference. We have continued to support this proposal which would save $19 million, mostly in SSI, in fiscal year 1984 and more in later years.

We have requested $2.44 billion in the social services block grant in fiscal year 1984. Our original request was for $2.5 billion, the full amount authorized by the current statute. However, in anticipation of some fiscal year 1983 funds provided under the recent "jobs bill" remaining in fiscal year 1984, we have asked for an offsetting reduction of $60 million.

On April 27, 1983, the Department sent to the Congress a proposal to amend the Social Services Block Grant Act to reduce the authorization, for fiscal year 1984 only, to permit direct funding of federally recognized Indian tribes under this program, and to authorize Indian tribes eligible for both this and the low-income home energy program to consolidate these funds at their option. In addition, we propose to clarify the statute to insure that funds under the act may be used for many of the activities and programs to ameliorate the causes of poverty which are currently funded under the Community Services Block Grant Act. We would ask, then to repeal the CSBG Act under a separate proposal sent to this Congress.

In the area of child welfare and foster care, we have requested $601.5 million for the family social services appropriation, including child welfare services, foster care and adoption assistance. Highlights of our legislative proposal sent to Congress on May 23 include:

Capping in fiscal year 1984 and thereafter the foster care program at the fiscal year 1984 estimated level of $440.2 million, eliminating the open-ended nature of this program. In addition, the cap will provide incentives to States to remove children from institutions and place them in a better and less expensive form of foster care and to provide services to preclude the need for foster care placement. Our proposal would not change open-ended Federal assistance for adoption of special needs children.

We propose folding the separate categorical program for child welfare training into the overall child welfare services program, and allowing the States to use service funds for this purpose. We are also proposing to make permanent the authority enacted in Public Law 96-272 to fund payments on behalf of children placed voluntarily in foster care.

Mr. Chairman, these are the major proposals of the Department of Health and Human Services which accompany the President's fiscal year 1984 budget and which come under the jurisdiction of the Senate Finance Committee. The administration is committed to continue working with you and others to bring Federal spending under control. We must constrain Federal expenditures wherever possible and restructure existing programs in such a way as to curb abuse, avoid duplication, target benefits, and streamline administration.

We will be happy to answer any questions that you or the members of the committee may have.

[Mr. Svahn's prepared statement follows:]

## STATEMENT BY JOHN A. SVAHN UNDER SECRETARY OF HEALTH AND HUMAN SERVICES

Mr. Chairman, members of the committee, it is a distinct pleasure to be here today to discuss the Administration's spending reduction proposals pending before your Committee. With your permission, Mr. Chairman, I will submit my entire statement for the record and provide a summary at this time.

Two crucial components of our 1984 legislative package—The Social Security Amendments and prospective payments to hospitals—have already been signed into law. This committee, under the capable leadership of Chairman Dole, made an important contribution in crafting this landmark legislation and facilitating its passage. The enactment of the Social Security Amendments has given us the opportunity to demonstrate that the Administration and the Congress can work together to resolve the problems that threaten the financial soundness of the Social Security and Medicare programs.

Before I review the other 1984 cost-savings proposals, I note that, at the midpoint of President Reagan's first term, HHS has succeeded in slowing the growth rate of social spending while preserving our compassionate mission. Still, an overwhelming 96 percent of the fiscal year 1984 HHS budget consists of entitlement programs. While we have achieved savings by carefully targeting the remaining 4 percent, only by controlling entitlement growth can we get a handle on federal spending and provide for the critical needs of program beneficiaries.

## HEALTH CARE FINANCING PROPOSALS

Despite our success in slowing the growth of Medicare and Medicaid, overall health care costs continue to climb. Without change, Medicare's Hospital Insurance Trust Fund will be depleted in 1990 under intermediate economic assumptions, or in 1988 under more pessimistic assumptions.

Hidden costs, unquestioned reimbursement, and the resulting absence of price competition among providers have worked to sustain the high inflation rate in health care. "Backward incentives" have contributed to rising costs and we need to correct this trend if we are ever to get control of the problem.

The Administration's health incentives reform program, introduced in the Senate by Chairman Dole on March 1, will control inflation and encourage competition in the health care marketplace by creating positive economic incentives for providers and patients to control costs. Our plan shares the responsibility for bringing down health care costs fairly among all participants in the health care market. I will highlight its principal components:

### *Prospective Payment to Hospitals*

A major component—and the centerpiece of this health incentives reform program—is the prospective payment legislation which was signed into law by President Reagan on April 21. This replaces the inflationary retrospective cost-based reimbursement system for hospitals with a system that establishes hospital payment rates in advance of the delivery of care.

### *Medicare Catastrophic Hospital Cost Protection Act—S. 643*

Another important element of our proposed reforms is the proposal to restructure Medicare cost-sharing under part A. In summary, the proposal would provide beneficiaries with protection against catastrophic illness by eliminating patient cost-sharing for any hospital days of care during a calendar year after the 60th day, and would be financed by modest increases in the deductible for stays fewer less than 60 days. This proposal would create incentives for savings where those incentives can work and better protect the Medicare patient needing long hospitalization.

### *The Medicare Voucher Act of 1983—S. 641*

This proposal would expand opportunities for Medicare beneficiaries to use their health benefits to enroll in a wider array of private health plans as an alternative to traditional Medicare coverage.

### *Health Care Financing Amendments of 1983—S. 643*

Included in this bill are a number of reform initiatives, such as:

Increasing the part B Medicare premium, in stages, until premium payments cover 35 percent of estimated program costs, moving closer to the original balance between premium and general revenue financing of part B.

Indexing the part B deductible to increase with annual changes in the Medicare economic index, helping to maintain the constant dollar value of the deductible.

Delaying the increase in the Medicare customary and prevailing charges for physician services for one year, as physician expenditures are the second largest component of Medicare spending.

Complementing the prospective payment legislation by modifying the allowable rate of increase in hospital costs to further control the growth in hospital expenditures.

Conforming the effective date of Medicare entitlement to the effective date for receiving Social Security benefits for individuals who retire at age 62.

Repealing the requirement that hospitals conduct utilization review of services provided, since we believe such activities can be effectively carried out by the Medicare intermediaries.

*Medicaid Proposals*

We are also proposing several Medicaid initiatives designed to give more flexibility to States, stimulate more cost-conscious behavior, maintain incentives to moderate program growth at the state level, and improve the efficiency of program operations. Highlights of the initiatives we support are:

A requirement for nominal copayments for both inpatient and outpatient services, with a State option to exempt from those copayments services to pregnant women, emergency services, and services to medically needy individuals enrolled in HMOs. We believe that if patients share in some of the costs, they and their physicians will reduce unnecessary or marginal utilization.

An extension of the reductions in Federal Medicaid payments authorized by the 1981 Budget Reconciliation Act, including the offsets, at 3 percent in 1985 and beyond, with States qualifying for percentage offset under certain conditions.

Mandating that States require Medicaid applicants to assign to the State their rights to medical support and third party payment for medical care, thus expanding the ability of State Medicaid agencies to become the payor of last resort and recover any health benefit payments due from other third party payors.

*Tax Cap (S. 640)*

This key component of our health incentives reform package makes changes in the tax treatment of employer contributions to health plans. It would encourage employers to provide an adequate level of health benefits, while eliminating the open-ended tax preference for health benefits over cash wages.

### MATERNAL AND CHILD HEALTH

We are proposing a number of changes in the Title V authorizing legislation to further enhance the ability of States to identify their own priorities and direct their resources to areas of greatest need. The proposals continue the block grant approach and include:

Eliminating the Federal set-aside of 10 to 15 percent of appropriated funds. We believe that the shift from a project grant approach to incorporation of the funds into the State MCH block grants will enhance the ability of States to carry out their programs.

Eliminating the matching requirement, since a large number of States are volunarily devoting state and local funds to carrying out major MCH programs and Federal funds do not constitute a major funding base.

Allowing State authorities to transfer up to 10 percent of MCH block funds to other block grants administered by the Secretary of HHS.

The Maternal and Child Health Block Grant has been funded at its full authorization level in fiscal years 1982 and 1983, and it also received an additional $105 million in fiscal year 1983 through the Emergency Jobs Bill. The President's January budget also proposed full authorization funding for fiscal year 1984. However, because of the increased 1983 appropriations in the Jobs Bill, a budget amendment to reduce the 1984 request by $38 million was sent to the Congress by the President on April 20, 1983, reflecting the President's policy of offsetting in later years the 1983 supplemental appropriations which were accelerations of planned future activity, and thus minimizing the impact of the jobs initiative on the multi-year deficits.

### AID TO FAMILIES WITH DEPENDENT CHILDREN

The Administration's proposals for the Aid to Families with Dependent Children (AFDC) program for fiscal year 1984 build on changes enacted by Congress during the last two years. I will briefly describe the effects of these program changes, and then discuss how our budget proposals make further program improvements.

Over the last two years the AFDC program has been significantly improved such as with the OBRA limits on disregard of earned income.

When these changes were first made, critics expressed considerable skepticism and rhetoric about their effect on working recipients. A recent independent national study conducted by a prominent non-profit organization, Research Triangle Institute, now provides factual information to dispel these myths. The study confirmed that:

Working recipients who lost eligibility because of the OBRA changes did not quit their jobs. The RTI study showed that only 15 percent of the recipients who were terminated were on the rolls at the end of one year, a rate which is the same (or lower) than the rate observed prior to OBRA. The RTI study also showed that working recipients who had lost eligibility and subsequently returned to the rolls stayed on for shorter period of time than they had previously.

Changes in the treatment of earned income did not decrease the work effort of AFDC recipients. The RTI study showed that the same percentage of welfare recipients began working after the OBRA changes as did prior to them—in spite of the economic conditions. Also, the rate of job loss by AFDC earners was virtually identical before and after OBRA, i.e. 18 percent.

OBRA changes save money. RTI estimated State and Federal savings to be approximately $24.4 million per month one year later. Equally important, the changes succeeded in targeting resources to those most in need.

In summary, the changes made over the last two years are a significant step toward this Administration's goals of restoring the AFDC program to its proper place as a temporary program of assistance for those unable to support themselves, and recognizing budgetary constraints at all levels of government.

## FISCAL YEAR 1984 PROPOSALS

Now let me turn to the fiscal year 1984 proposals. Several of our budget proposals are designed to further strengthen work requirements and improve the employability of recipients. This Administration believes that all able-bodied individuals who request assistance should be involved in some type of work-related activity from the day they apply. We propose that:

All applicants who are able to work be required to begin searching for employment as soon as they apply for assistance. Those who cannot find employment must actively participate in a Community Work Experience Program (CWEP) or a subsidized employment program. Sanctions are to be applied against individuals who voluntarily terminate their employment or reduce their hours of employment without good cause.

In determining a family's need for assistance, all sources of income available to the family are considered. Parents and minor siblings living with an AFDC child should be included in the assistance unit, eliminating inequities caused when families exclude members with income from the assistance unit in order to maximize welfare benefits. This recognizes that primary responsibility for support resides within the immediate family and not with the government. SSI recipients who have a separate public benefit would continue to be excluded from the AFDC unit.

Assistance be discontinued to an employable parent or other caretaker relative when the youngest AFDC child reaches age 16, a point at which the caretaker relative is sufficiently free from child care responsibilities to enable him or her to secure full-time employment. Let me emphasize that the child's AFDC benefits is not affected by this proposed change.

Minor caretaker relatives who are not or have never been married be eligible for assistance only if they reside with their parents except under limited circumstances, helping to restore parental control over their minor children and removing the possibility of minors using AFDC in order to establish economic independence.

States be required to adjust the portion of the AFDC grant allocated for shelter and utilities for any assistance unit sharing a household with others, accurately reflecting recipients' actual needs and giving other household members greater incentive to contribute their fair share to household support.

In summary, Mr. Chairman, the RTI study and information from other sources have established that the changes made to the AFDC program in 1981 and 1982 have been successful in reducing welfare dependency among employable individuals and in targeting assistance to those most in need. Our overriding concern in developing these proposals is to give AFDC children and their families the kind of support that really helps in the long run. We believe that the way to help children is to help families achieve self-sufficiency and avoid welfare dependency. The fiscal year 1984 proposals are designed to build upon the progress we have made over the past two years towards meeting these objective.

## CHILD SUPPORT ENFORCEMENT

The proposed legislation is designed to improve State efforts to collect child support on behalf of both AFDC and non-AFDC families changing the way the Federal Government finances the program and mandating that States use methods that are proven effective and efficient. Our proposals include:

Establishing a funding approach with a clear focus on performance, tangible recognition of superior performance, and allowing for an orderly transition through a three year phase-in to the new means of program financing to strengthen and improve the provisions of services to both AFDC and non-AFDC families. The proposal would repeal the allocation of gross AFDC collections, and substitute, on a quarterly basis, a deduction from total AFDC collection of the total administrative expenditures (for both AFDC and non-AFDC components). The resulting net amount would be shared between the Federal and State governments based on each State's AFDC matching rate. A key element of this proposal is to permit a considerable amount of Federal funds to be paid to States in performance awards based on their achievements in collection for both AFDC and non-AFDC cases.

Requiring all States to include in their CSE programs relatively simple and inexpensive enforcement techniques to strengthen and improve the program, such as mandatory wage assignments, State income tax offsets, and administrative or quasi-judicial procedures which have been shown through program experience, studies and the endorsement of State and local program officials to be effective and efficient methods of collecting child support.

On a nationwide basis, there is an enormous untapped potential for increasing child support collections. Program effectiveness varies widely from State to State. In fiscal year 1982, 48 States produced only 12 percent of the welfare savings. These same States, however, represented 68 percent of the total administrative expenses for that year. Clearly in many States there is room for improvement.

An estimated $66 million would be saved by the implementation of the entire child support legislative package. These Federal savings, moreover, are achieved by strengthening the Child Support Enforcement program also resulting in a total savings to the States of $398 million, a $38 million increase in fiscal year 1984 from current law projections.

As you of course know, most of the Old-Age, Survivors, and Disability Insurance (OASDI)—or Social Security—portion of our budget request this year was comprised of NCSSR recommendations and incorporated in the Social Security Amendments of 1983, Public Law 98-21. President Reagan and all of us in the Administration were pleased by the work of this committee and the Congress as a whole in moving quickly, decisively and in a nonpartisan spirit to deal with that most comprehensive and significant legislation.

The fiscal year 1984 budget reflected two legislative changes not addressed in Public Law 98-21: disability initiatives and debt management efforts.

Disability Benefits: On June 7, Secretary Heckler announced several new steps we are taking to improve the administration of the disability program, especially handling of the continuing disability reviews mandated by the 1980 legislation. We are recommending:

Permitting a disability beneficiary who appeals an SSA decision to stop benefits because he or she is not disabled to elect to have continued until the beneficiary has had a face-to-face evidentiary hearing on the appeal. When the temporary payment provision of the Virgin Islands Tax bill expires in fiscal year 1984, we recommend that it be made permanent but modified to continue benefits throughout the reconsideration process.

Changing the present requirement that we review, on a pre-effectuation basis, 65 percent of favorable disability determinations, and providing us with the flexibility to review whatever percentage of both favorable and unfavorable determinations would result in the best quality of decisions in the most cost-effective manner.

We look forward to working with this committee in the future on these two important changes in the disability program.

Debt Management: One legislative proposal contemplated in the area of debt management is to authorize recovery of overpayments in one Social Security administered program from benefits payable under another such program. Last year the Senate adopted a provision to permit recovery of SSI overpayments from future OASDI benefits, which substantially incorporated this proposal, but the provision was not agreed to in conference. We continue to support this proposal which would save $19 million—mostly in SSI—in fiscal year 1984 and more in later yeas.

## SOCIAL SERVICES BLOCK GRANT

We have requested $2.44 billion for the Social Services Block Grant in fiscal year 1984. Our original request was for $2.5 billion, the full amount authorized in the current statute. However, in anticipation that some fiscal year 1983 funds provided under the recent "Jobs Bill", will remain available in fiscal year 1984, we have asked for an offsetting reduction of $60 million.

On April 27, 1983, the Department sent to the Congress a proposal to amend the Social Services Block Grant Act to reduce the authorization (for fiscal year 1984 only, permit direct funding of Federally recognized Indian tribes under this program, and authorize tribes eligible for both this and the Low-Income Home Energy Block Grant Program to consolidate these funds at their option. In addition, we propose to clarify the statute to ensure that that funds under the Act may be used for many of the activities and programs to ameliorate the causes of poverty which are currently funded under the Community Services Block Grant Act. We would repeal the CSBG under a separate proposal also sent to the Congress.

### CHILD WELFARE/FOSTER CARE

We have requested $601.5 million for the Family Social Services appropriation, including Child Welfare Services, Foster Care, and Adoption Assistance. Highlights of our legislative proposal sent to Congress on May 23, include:

Capping in fiscal year 1984 and thereafter the Foster Care program at the fiscal year 1984 estimated level of $440.2 million, eliminating the open-ended nature of this program. In addition, the cap will provide incentives to States to remove children from institutions and place them in better and less expensive forms of foster care and to provide services to preclude the need for foster care placement. Our proposal would not change open-ended Federal assistance for adoption of special needs children.

Folding the separate categorical program for Child Welfare Training into the overall Child Welfare Services program, and allowing the States to use service funds for this purpose. We are also proposing to make permanent the authority enacted in Public Law 96-272 to fund payments on behalf of children placed voluntarily in foster care.

Mr. Chairman, these are the major proposals which accompany the Fiscal Year 1984 budget and which come under the jurisdiction of the Senate Finance Committee. The Adminstration is committed to continue working with you to bring reckless Federal spending under control. We must limit Federal expenditures wherever possible and restructure existing programs in such a way as to curb abuse, avoid duplication, target benefits and streamline administration. I will be happy to answer questions that you or Members of the Committee may have.

Senator DANFORTH. Mr. Donnelly, thank you very much. You have done an excellent job as a pinch-hitter, and we appreciate your being here.

On the second page of the statement, with respect to medicare, right at the top of the page you say that "Without change, medicare's hospital insurance trust fund will be depleted in 1990 under intermediate economic assumptions, or in 1988 under more pessimistic assumptions."

We have recently enacted new legislation with respect to medicare, and particularly with respect to prospective payment. This statement by the Department means that, even with the new legislation, medicare is going to be depleted. Hospital Insurance will be depleted in 1990, with intermediate assumptions.

Mr. DONNELLY. That is correct, Mr. Chairman. As you may recall from consideration of the Social Security Act amendments the prospective payment provision was budget-neutral with relationship to medicare changes in hospital payment that were incorporated in TEFRA last August. It was not a budgetary factor at that point.

In addition, the administration has sent forth other proposals in the medicare area. And it is even with the inclusion of these proposals that are currently before you, additional proposals in the medicare area, that this statement with respect to the trust fund balances is made.

Senator DANFORTH. So even with changes that are spelled out in this testimony, it would still be——

Mr. DONNELLY. We would get one more year, from 1990 to 1991, with the other pending changes that are before you.

Senator DANFORTH. Why bother to make the changes?

Mr. **Donnelly**. Well, we feel a responsibility, Mr. Chairman, to continue to work in this area.

Dr. **Rubin**. Senator Danforth, I think that is an excellent question. I think the answer is very straightforward.

I think we need to begin to enact the reforms that the President proposed in the health incentives reform package to build a base from which to address the medicare program. I think it is from that base, by those beginning steps, that we can begin to decrease the rate of rise of health care costs in the medicare program. But, that would require the passage, if you will, of the proposals presented in the President's health incentives reform package—the tax cap proposal, which we will talk about next week before this committee; extending catastrophic health insurance to the elderly; taking another look at part B financing—all of these. I think that road needs to be traveled if we are to have any success at all in the 1990's.

Senator **Danforth**. Well, as I understand it, as I recall the figures on Medicare, in 1970 the cost was $7 billion, in 1983 $59 billion, in 1990 $137 billion. Is that right?

Mr. **Donnelly**. That's close.

Dr. **Davis**. Yes.

Senator **Danforth**. That is with these changes?

Mr. **Donnelly**. Yes, sir.

Dr. **Davis**. May I make a comment?

Senator **Danforth**. Sure.

Dr. **Davis**. If you look long-range, in order to preserve the integrity of the hospital insurance trust fund, we find that we will either have to reduce the outlays by roughly a third or to increase the revenues coming into the trust fund by something in the neighborhood of almost double what they are now, or a combination of the two. It seems prudent to us to try to manage the fund better by trying to decrease the outlays, and one does that by changing the behavior patterns of all of the individuals and changing their expectations. That is part of what we designed the health incentives proposals to begin to do.

Senator **Danforth**. Now, you say that to accomplish what results we would have to either what? Double revenues or reduce payments?

Mr. **Donnelly**. Reduce outlays by a third, or double revenues.

Senator **Danforth**. In order to accomplish what?

Mr. **Donnelly**. To keep the trust fund solvent at the current outlay rates or current beneficiary rates.

Dr. **Davis**. There will be a new trust fund report out probably in a couple of weeks, Senator Danforth, and that might change slightly, but that is in the realm of what we anticipate.

Senator **Danforth**. But shouldn't we face up to that problem now as opposed to going through extremely agonizing, very controversial, and inconsequential tinkering?

Dr. **Davis**. Well, it seems to me that we are facing up to that, because this is part of our long-range effort. These proposals were designed, as I said, to begin to change behavior patterns, and in terms of changing behavior patterns we will then begin to slow down this overall rate of growth that has been occurring.

**Senator DANFORTH.** But this does not accomplish the one-third reduction in outlays or the doubling of revenues.

**Dr. DAVIS.** It seems that it would prudently begin to slow the growth rate down. It probably won't accomplish all of it, but it will begin us down that road.

Second, I would like to point out that we do have the Quadrennial Social Security Council that every 4 years is supposed to look at the trust funds and report back on them.

About a year ago Secretary Schweiker did ask that this particularly advisory council concentrate on medicare, and we expect that report in the fall.

**Senator DANFORTH.** Let me ask you—for all of the changes in medicare, medicaid, all of the programs that you have gone through in your testimony, what is the total deficit reduction for 1984, 1985, and 1986, if you know.

**Mr. DONNELLY.** I believe we can supply that for the record, Mr. Chairman. My recollection is that for medicare it is $1.6 or $1.7 billion for 1983. I will provide this particular page for the record, but the information provided here is that for medicare and medicaid—now, you were speaking only of medicare, Senator Danforth?

**Senator DANFORTH.** No, everything that you have proposed.

**Mr. DONNELLY.** Everything that we have proposed in what I have just included in my testimony is $3.02 billion in 1984 and $4.75 billion in——

**Senator DANFORTH.** Would you do that again? I'm sorry; in 1984 it would be what?

**Mr. DONNELLY.** $3.02 billion, and in 1985 $4.8 billion. I don't have the 1986 numbers here.

**Senator DANFORTH.** So in those 2 years it is just a little under $8 billion?

**Mr. DONNELLY.** That is correct.

**Senator DANFORTH.** Well, my problem with this is that the way that the administration fights the budget battle is to come up with long lists of controversial changes which, when added up, produce very minor results with respect to reducing the deficit.

Yesterday Senator Dole quoted Senator Dirksen's famous comment, "A billion dollars here, a billion dollars there, and sooner or later it adds up into real money." When you are talking about $200 billion deficits, I don't know that a billion here and a billion there does it. And, as you have pointed out, the explosion in entitlement programs has been a leading cause of our problem. If 96 percent of the spending of HHS is entitlement programs, I just don't see how we are going to come to grips with the problem by presenting to the Congress a package of these specific little items which produce only $8 billion in a 2-year period of time.

Furthermore, I don't understand why we use up the energy to fiddle around with medicare when it is going to produce only a 1-year delay in bankruptcy. Shouldn't we be addressing the real problem?

And it is not just using up energy. I think that the problem is that when we concentrate on so many tiny little items, the result of that is to lull the American people into thinking that a major problem can be solved by tinkering and not by a real structural reform.

Senator Boren and I have made a proposal with respect to indexing. It doesn't touch medicare, of course, but it is a broad and I think understandable position to present to the American people—Consumer Price Index minus 3 percent for a 4-year period of time for all indexing, taxes and spending. It seems to me that that kind of broad thing would not only produce many more dollars but also be understandable by the American people, and be perceived as fair.

One of the problems with these laundry lists is that people who are disproportionately hurt by any specific measure say that it's unfair, and therefore one of the problems that the administration has to battle is the constant allegation of unfairness. So it would seem to me that a broader and more comprehensive approach would be viewed as fair and I think would be more acceptable by the people.

Dr. RUBIN. Senator, if I might respond to some of what you said. In the tax cap proposal—hoping not to tip my hand for next week—we are proposing $32 billion, or we are estimating roughly $27 billion in increased revenues as a result of that proposal in the 5 subsequent fiscal years. Three-fourths of those increased revenues will come from people earning more than $20,000 per year. The average tax increase, for example, in 1984 for people with incomes of $10-15,000 would be less than $2 per month.

So I think that there is a proposal that meets your criteria. Now, $27 billion may not be a lot of money, either. But the proposal would: 1) raise a substantial amount of revenue with a positive impact on the deficit; and 2) be perceived as fair since the tax is progressive. The proposal would limit an existing tax incentive that, for example, gives households earning between $50,000 and $100,000 this year roughly $625 worth of tax benefits whereas those earning between $10,000 and $15,000 would only get about $80 of tax benefits. It seems that the administration's proposal limit on this tax benefit would be one proposal that might meet your criteria of having some real impact as well as being perceived as being fair.

Senator DANFORTH. Senator Boren?

Senator BOREN. Mr. Chairman, I don't have any questions at this time, and no others here have questions that they are anxious to ask—we have a rollcall beginning—but I do just want to affirm my support for the statement that you made just a minute ago, that I think one of these days we are going to have to face up to a broader solution and one that deals in tens of billions of dollars and indeed finally into the hundreds of billions of dollars of figures of savings before we can get anything done, and tinkering around with small amounts is not going to solve the problem or face up to what is going to happen to this country if we continue to run deficits in the magnitude of $200 billion a year.

We can't simply say that all of the entitlement programs are off limits and do the job, and I think that Senator Danforth and I are both trying to plant the seeds at least, at this point, of a possible solution that would cut across the board and would affect everyone, and put everyone in the country in the same boat together, while exempting those who are really hard-pressed and on the borderline of being able to survive and have adequate nutrition and meet the basic needs.

So I would just urge the administration to give some thought to the proposal which we have made, which Senator Danforth has said would be an adjustment at both ends of indexing on both entitlement programs and revenues, to try to do something that will add up to the kinds of dollars that will get us moving.

I think everybody in the country realizes we cannot say that a third or a fourth of the entire budget—in the case of your Department, as you said, is well over 90 percent—is off limits and still come up with any basic solution to our budgetary problems.

So I just want to affirm my support for what Senator Danforth has said. I won't take any more time now. Senator Long has some questions that I know he wants to ask.

Senator DANFORTH. We have five bills now on the vote; should we come back for your questions, Senator Long?

Senator LONG. I would like to interrogate these witnesses; so, if it's all the same, I would like to. [Laughter.]

And I don't have in mind being rough on anybody. I just want to ask a few questions. So if it is all the same, then, I will ask that the witnesses stick around.

We have to make five votes, I understand?

Senator DANFORTH. No, just five bills. There is just one vote that I know of.

Senator LONG. OK. Thank you very much. We will be right back.

[Whereupon, at 10:41 a.m., the hearing was recessed.]

### AFTER RECESS

Senator DANFORTH. Senator Long?

Senator LONG. Thank you.

First I have some questions from Senator Bradley that I would like you to answer for the record.

Mr. DONNELLY. Yes, sir.

Senator LONG. Mr. Secretary. We had testimony yesterday from Mr. Leon Ginsberg who administers the welfare program in West Virginia. He was speaking for the organization of all State welfare administrators. His testimony included several very specific recommendations. I would like to get your thoughts on two of the proposals he made.

One, Mr. Ginsberg suggested giving the States a great deal of additional flexibility in designing the unemployed parent program. For example, he suggested that States might be allowed to operate such a program only in areas or times of high unemployment rather than as a permanent statewide program. He also suggested that, given sufficient flexibility, States might want to use the "work supplementation" approach in which welfare funds are used to subsidize jobs rather than to provide assistance.

What is your reaction to that?

Mr. DONNELLY. Without knowing the details of that program, Senator, we would certainly be prepared to take a look at it. We know Mr. Ginsberg and his work in West Virginia well, and I have met him personally on a visit to that State. If he has some details that he can share with us, we would certainly like to look at them and perhaps respond to you.

Senator LONG. Well, my thought is that we would be better off subsidizing jobs than just paying people for doing nothing. I think that is our big problem, making welfare more attractive than work, in altogether too many cases.

Now, second: In the case of child support, Mr. Ginsberg's statement opposes the administration's plan to restructure program financing but supports your proposal for a more flexible and performance-related audit penalty. He also suggests that the Postal Service be required to be more cooperative in helping States to locate absent parents.

What is your thought about that?

Mr. DONNELLY. Well, we are not unsupportive of where he is. We would have to see some specifics, again. If he is responding only to our proposals, I would have to check on the West Virginia situation to see why he wouldn't like the restructuring proposal per se.

You know, it is very clear that in the proposal we have made about restructuring, we are trying to advantage States for performance in both AFDC and non-AFDC, and in some of the other areas he is talking about, I am told that the Postal Service says they can do some of the changes he is asking for without legislation. So maybe that is something he should address to the Postal Service.

Senator LONG. Well, I certainly share the administration's desire to control the costs of the welfare program, but I am a little puzzled by your views that we should do this by imposing a long list of mandatory policies upon the States.

We had hearings on this matter back in 1971. I was very much impressed by the testimony given to this committee by the Governor of California, Mr. Ronald Reagan. His opening point was the following:

> States are better equipped than the Federal Government to administer effective welfare programs if they are given broad authority to utilize administrative and policy discretion.

Do you agree with that statement? And if so, how do you feel about a proposal to increase State flexibility while changing the way that we fund the program, so that States would retain 100 percent of the savings they achieve or would have to pay 100 percent of the additional costs that they incurred in that program?

Mr. DONNELLY. I think I am better prepared to respond to your opening question about how do I feel about President Reagan's statement when he was Governor with respect to State flexibility. I think you would find that all of us at this table concur with that.

As a matter of fact, the President himself has from time to time tried to move even more assertively in this area. Certainly we are all aware of New Federalism proposals and others, particularly in the welfare areas.

But we have to balance this off with the fact that at the moment we have an open-ended program, and we are charged with operating the program the way that it is currently on the books.

Senator LONG. Well, basically what I am suggesting would be that we move away from the open-ended program. I'm asking you how would you feel about that? I believe it was suggested in this committee before. If you want to economize, that's one way to economize, to stop the open-ended part of it.

Mr. **Donnelly**. Are we talking about child support enforcement at the moment, or about AFDC?

Senator **Long**. About the welfare program, period. I'm talking about the AFDC program—the whole program. I'm talking about giving the States more flexibility, which is what President Reagan seemed to advocate, and I think he probably still favors that. I would be very much surprised if he didn't. And I am talking also about saying that insofar as the States saved money, it's theirs to keep.

Mr. **Donnelly**. I believe it is our understanding, Senator, that the kind of work experience program we are now asking the States to implement is currently permissive, and we have had a very good experience with work experience programs, and the data are coming in to sustain that; if the States could implement that and many other types of work experience programs they would have a lot of flexibility about the kind of program that they would run. The reports and the examples we are given, which we would be happy to supply for the record, I think are pretty exciting.

[The information follows:]

Work requirements authorized under Federal statute include the Community Work Experience Program (CWEP), Employment Search, the Work Supplementation Program (WSP) and the Work Incentive (WIN) and Work Incentive Demonstration (WIN Demo) programs. Each State is required to operate a WIN or WIN Demo program. Title IV-A administered CWEP, employment search and WSP are options available to each State. Looking at some of the States which have made significant use of these options, we find:

Michigan during the quarter April through June 1983, registered 38,011 individuals in its work program and 8,331 entered unsubsidized employment. During this period, 2,109 left welfare with a State estimated savings of $649,899. Additionally, 6,239 had grant reductions resulting in $588,389 savings. This is at a time when unemployment has hovered around 16–17 percent. Michigan has made extensive use of both CWEP and employment search in achieving these results. These programs are being operated with ¼ the staff that was assigned to the former WIN program.

West Virginia has focused its work requirement through CWEP. From January 1, 1982 to the present, 8,359 recipients have participated in CWEP assignments. Of these recipients, 1,819 or 21.8 percent have entered unsubsidized employment. A larger than normal percentage of case closures (33.7 percent of 5,393) results from employment derived from the program. West Virginia's unemployment rate has been around 21 percent.

Oklahoma, making intensive use of a combination of CWEP and WIN Demo job search activity, has increased the number of applicants and recipients entering employment from 2,020 in the last full year of WIN activity to 3,511 in 1982 and an anticipated 4,000 in 1983.

Under the new options available to the State, Oklahoma is applying the work requirement to a much greater segment of the AFDC population and has doubled the number of individuals entering employment. According to State estimates, the new State work program effectively reduced the AFDC caseload by ten to fifteen percentage points.

Oregon, using an intensive employment search program for applicants and recipients, reported for the quarter January through March 1983, that out of 12,027 registrants in its work program, 4,658 entered unsubsidized employment. Of these, 1,118 recipients left welfare, 3,433 had grant reductions and 110 applicants were diverted from needing welfare. Additionally, 418 recipients were sanctioned for not participating and 499 applicants chose not to meet the requirement and did not proceed with their application. The State estimates monthly savings or avoidance at $705,090.

North Carolina has implemented in six counties a work program consisting of job search, CWEP and job preparation. As of March 1983, 651 of the 2,734 individuals registered for the work requirement had actively participated. Of these 651 participants, 291 found paid employment. There were 89 individuals sanctioned for failure to meet the work requirement.

New York has reported that about 29 percent of its CWEP particpants are entering employment. New York also estimated that its CWEP requirements were successful in deterring about 9 percent of the potential program participants. Overall, according to a conservative estimate, the CWEP produced savings of about $2 for every $1 in administrative costs.

Mr. **Donnelly**. This tells me that if you would say—"Look, this is a good initiative to get into. Now, get into it and then do it in whatever way you feel is useful", meeting some very, very limited criteria—we are in fact going to reduce those welfare outlays.

Senator **Long**. Let me just say this to you, Mr. Secretary. I have been involved in this program at the State level as well as at the Federal level in my life. When I talk to those fellows down at those State legislatures—and I know particularly at the Louisiana legislature—they complain bitterly that when they have had a suggestion, it doesn't seem to matter that they possibly were right based on their own experience and knowledge of their population. It doesn't matter that their suggestion is in many cases consistent with the way the majority of us on this committee would think. They are just told, "Oh, no, if you do that, the Department in Washington will cut off or drastically cut back on the funds available to you. The Federal funds will be cut off if you dare do some of these things even if they are a good idea for moving more people into employment."

Now, I don't have any doubt at all that Ronald Reagan would agree with their philosophy, that they should be trying to put those people into jobs. That is what he was trying to do when he was Governor of California. And he had the same problem of the department up here cutting him off because he was doing what the people of California wanted. And I don't know of any of the things he stood for that appealed more to the rank-and-file people of Louisiana when he ran for President. We have a big welfare program. He came before this committee at the time that President Nixon was pushing the family assistance plan. He was the most effective and impressive witness we had before the committee during the hearings on that matter. Certainly, of all the public officials and public employees that testified he made the best statement.

The best private statement, I guess, was made by Roger Freeman from the Hoover Institute, who was reflecting exactly the same philosophy. I suspect that was where Mr. Reagan got some of his ideas from; but between those two, those were the two best witnesses, period. And their statements were, I think, just not subject to challenge.

I would be curious to know why Mr. Reagan's philosophy is not reflected by your position before this committee.

Dr. **Rubin**. Senator, I think that to a very large extent that philosophy is reflected in this position. No. 1, as Mr. Donnelly mentioned, our strategy is to encourage people to work, and indeed to make some requirements in that regard.

No. 2, the States do have discretion as to how these programs to put people to work can be implemented. Indeed, we see that various States have responded in different ways.

Currently, in some of the provisions—for example, the proration for shelter and utilities—we allow the States great discretion; and in point of fact it appears that the State of Kansas, for one, and we understand there may be others, have come in and asked the Secretary for that flexibility, and we have granted it to them.

So I think that the philosophy behind the administration's program is to grant the States flexibility within the broad philosophical guidelines laid down by the President which are precisely as you have articulated them: to get people off welfare and back to work.

Senator **Long**. Well, when this administration first came, in my understanding was that the administration expected to recommend that we turn this welfare program over to the States.

Now, that was seriously considered down at the Department, wasn't it? I see you nodding—is that correct

Dr. **Rubin**. Well, as part of the President's——

Senator **Long**. I would like to ask the Secretary to respond to that.

Mr. **Donnelly**. It was certainly a part of the discussions in the New Federalism Initiative, yes.

Senator **Long**. My understanding is that the matter was right on the front burner.

Mr. **Donnelly**. That is correct.

Senator **Long**. And then there was conversation by some people who I think had good intentions that, no, rather than first turn it back over to the States we first ought to try to clean the program up and then turn it back over to the States. So that was suggested, and that had some appeal. Now I am afraid by the time you get through up here you may not have achieved either one. My thought is that you ought to achieve one or the other. If you are not going to turn it over to the States, then you ought to clean the program up. If you don't achieve either one of them, I think that that would be a sad travesty from someone who starts out with all good intentions.

Now, let me ask you about the child support program.

Mr. **Donnelly**. Senator, if I could just make one comment on your previous question. I think we would agree with you that if the program cannot be moved or is not possible to be moved to the States, as the President had thought at one time, then it ought to be cleaned up as well as we are able. And those are the kinds of proposals we feel we are putting forth.

Hopefully, in the dialog that ensues with you and this committee, we can convince you, or you can convince us, and we can come to an equitable understanding on those proposals.

It turns out that, unfortunately, Ronald Reagan couldn't be President and head of the National Governors Association simultaneously; because, had he been, perhaps the Governors Association would have been a little more receptive to having the welfare program placed as part of the State package.

Senator **Long**. It has been my privilege to discuss this matter with Ronald Reagan while he was Governor of California, before he became the President of the United States, and now I look forward to discussing it with him as President of the United States. I have been pleased to hear him as a witness before the committee, and my impression in discussing it with him is that insofar as he and I had a difference of opinion, I usually would wind up agreeing with him. There wasn't much to argue about because we were so close together in the way we viewed the problem.

And I didn't start out from the same place he start out. I started out as a welfare advocate. I came here having helped to put together a Louisiana welfare program, which at that time whenever the welfare administrators would meet they would say that Louisiana had more of its people on welfare than the State of New York, and I guess it was correct. We were really going all out with welfare at that point. We haven't particularly cut back, but New York is coming along with what we have been doing for people, especially for the aged.

Well, we have the five bells again. I want to come back because I have some more questions, Mr. Secretary.

Mr. DONNELLY. Yes, sir.

[Whereupon, at 11:13 a.m., the hearing was recessed.]

### AFTER RECESS

Senator DURENBERGER. The hearing will come to order. I am going to ask the ranking member of this committee—I know that he has a strong interest in the area that this panel is supposed to be expert in; but we also have at least three other panels, most of whose members are from out of town. And I would propose, if it is all right with my colleague from Lousiana, to excuse this panel either now or at some very early point so that we might be able to get to some of these other people as quickly as possible.

Senator LONG. I think I can finish my part of this program in fairly short order, Mr. Chairman. If I may, I would just like to ask a few more questions.

Senator DURENBERGER. All right.

Senator LONG. Let me ask this question: How much is the Federal Government spending to identify the fathers of these AFDC children, and all absent fathers—AFDC as well as those who are not on AFDC?

Mr. DONNELLY. I'm not sure I have that answer at hand. Mr. Chairman. I will check briefly. If it is not here, we may have to supply that for the record.

Senator LONG. Can't you ask around the room? Don't you have some assistants around here?

Mr. DONNELLY. That is what I'm saying. Let me ask and see. If that figure is available right here, I will be happy to give it to you.

[Pause.]

Mr. DONNELLY. I am advised we don't have the dollars, but we will get them for you and provide it for the record.

Senator LONG. Well, can you give it to me as a percentage of your overall program?

Mr. DONNELLY. As far as that particular breakdown, Senator—we have what we are spending, of course, on the entire program; but what we are spending specifically to identify absent fathers or what the States are spending, I'm not sure we have at this point.

Senator LONG. Well, you've got a lot of people in this room here from the Department. Do you mean nobody in this room has that information even in his briefcase. Can tell me how much is being spent to identify these runaway fathers?

Mr. DONNELLY. Senator, we will simply have to supply that figure for the record. The people who are here are knowledgeable in the program, and if they don't have that readily at their fingertips then it's a figure that is going to have to be researched more thoroughly.

Senator **Long**. Now, that supports what my fear was all the time. My fear was that you don't have anybody in a position of responsibility either at the top or close to the top who is sufficiently conversant with this problem of identifying those fathers. My feeling is that until we identify the fathers we are not going to be able to gain support for those children from those fathers. Is there any doubt in your mind about that—that until such time as we identify who the father is that we are not going to be able to get the fathers to make any contribution?

Mr. **Donnelly**. Well, clearly, if you are going to pursue someone to fulfill his court-ordered responsibility in child support, you have got to know who you are pursuing. And to the extent that we have those identified, obviously we and the States are pursuing them.

It is an area, Senator—and I think you know this very well because of your long association with this program—in which there is an enormous room for continued improvement. In the existing program within the States, as I mentioned earlier, 48 States produced only 12 percent of the savings, and yet those States represented 68 percent of the administrative costs.

Senator **Long**. How many? Forty-eight?

Mr. **Donnelly**. Forty-eight of the States—48 States—produced only 12 percent of the savings. And yet those same 48 States represented 68 percent of the administrative expenses for fiscal year 1982.

Senator **Long**. Now, if you had a proposal up here, say that in those States they just don't get anything, if they represent 48 percent of the cost and are not achieving anything. I would support that.

Mr. **Donnelly**. Well, Senator, the restructuring proposal that we will have is in the President's budget—and I realize that the particular piece of legislation embodying that proposal is not yet in front of this committee. It is my understanding that we will have it up here within literally a few days, probably before these hearings conclude. I think it will be something you will find encouraging, hopefully you can embrace and other members of this committee can embrace, but it will address precisely that concept. And the concept is: you ought to be reimbursed commensurate with the amount of activity and effort and results that you are getting.

There are tremendous incentives in this restructuring for those who are going to improve their efficiency, because what's going to happen is that if they improve their efficiency and find those absent fathers and gain these payments, and they improve their dollar cost per recovery dollar, they are going to keep a significant and greater substantial share of that savings in their pocket.

State savings are on a sliding scale with an unlimited top on it; the more they collect the greater share. As long as that is the case they are going to continue to pursue it.

And in addition to that, we are making some other add-ons to this proposal that will provide some new incentives in the non-AFDC area as well.

Senator LONG. Now, I am concerned, Mr. Secretary, in identifying whether States are doing a good job of child support enforcement, that the percentage of recovery they get should not depend on what somebody is or is not doing in some other part of the welfare program.

Mr. DONNELLY. Right.

Senator LONG. I regret to say—I don't know how bad it is now, but in the early days of this child enforcement program I would go speak to these IV-D people, and they were the ugly ducklings of the program. The people who had their Santa Claus suits on looked down their noses at these people as though they had no business being in the welfare program at all.

The IV-D people were the people who tried to do what the taxpayer wanted. They were out there identifying those fathers and pursuing those fathers to make them contribute to the support of their children. That other crowd felt like they were the only ones working for the clients, trying to put more and more on the roll all the time.

I can appreciate both sides of the argument. I can recall a time when we in Louisiana really wanted to put everybody on the rolls of the program for the aging. My Uncle Earl had gone out and campaigned for Governor, and he said, "Grandma, you just look me in the eye. You are going to get the $50." That's what he promised them, $50 a month, and they were counting on it. I believe he tried to put them all on it. He said, "No embarrassing questions will be asked." And we did everything we could to try to get the Federal Government to cooperate in fulfilling that commitment. We went as far as we could with it.

But the child support program, as I understand it, actually makes money for the Government. Now, can you tell me, on the overall child support enforcement program, how do the collections compare with what it saves the program to the taxpayer?

Mr. DONNELLY. In the aggregate it is quite good, because of the performance of the high-performance States. You may have the figures close at hand, but my understanding is that we have recovered about $8.8 billion over the life of this program, and about $3.8 billion of that has been in the AFDC area. The balance, $5 million, has been in non-AFDC, which I think is a highly-overlooked fact, so that it has been well targeted into both areas and is making significant progress.

Senator LONG. Now, I just want to pin this point down a little before you explain the rest of it, because I want to hear that, too. But the point I am trying to get to is that this program has been actually saving for Government $2 for every dollar the program has been costing us.

Mr. DONNELLY. I'm not sure about that. The figures I have just been given are that in fiscal year 1982 there was a $200 million savings to the taxpayer in this program.

Senator LONG. Two hundred million net saving?

Mr. DONNELLY. That is correct.

Senator LONG. All right.

Now, you and I know that the way you figure these savings does not take into account the things that are somewhat nebulous, or the intangible items. For example, they don't take into account all of the money we are saving by proceeding against the fathers whose families are not on welfare. Isn't that right? They don't put any saving on that.

Mr. **Donnely**. That's correct.

Senator **Long**. All right.

Yet some of these people would otherwise probably have to go apply for welfare. But beyond that, the important thing there is if you want this program to achieve what it is capable of doing, you ought to have the same situation for these middle income and lower-middle income people that you have for the affluent people. You ought to have a situation where those fathers know they are going to have to support their children because society will be 100 percent behind the mother and the children. Until we achieve that, it will cost us tons of money that we shouldn't have to spend on welfare.

But even beyond that, you take a person like the one who inspired me to get involved with this. She is retired now, but a fine woman looking after her children. The father leaves, he goes off and takes on a second family—or at least a second wife in some other State. She is left trying to look after those children with no help. She goes down to the welfare offices or to any part of government, and there is no help available to her. As a practical matter, they tell her nothing could be done.

Now, as a lawyer I have been on both sides of this. I represented mothers and I represented fathers, too. My impression was that, prior to the time Congress got involved, those fathers could walk away from those children and get away with it, especially if they went across the State boundary. A lawyer couldn't do anything to help that poor mother; it was just beyond his reach, and the father knew it.

Now, I would hope that this administration is not going to abandon the child support program. What we should do is to make it so effective that it becomes "the" thing to do.

When some character goes to a barroom and has a couple of drinks and sets up a couple of rounds on him and proceeds to brag about how he is not supporting his children, it ought to be so that everybody says, 'Well, I sure hope they get you, you lousy so-and-so, because I'm paying to support my children, and you ought to be made to support your children." That's how it ought to be. Do you agree with that?

Mr. **Donnelly**. Senator, not only do I agree with that, I can assure you that the Secretary agrees with that. And in the time that she has been active in the Department since her confirmation, she has pressed precisely on some of those points.

To be very candid with you, that is one of the reasons that the legislative package is not in front of you, although almost every other piece of proposed legislation from this Department is up here. It was because she wanted an opportunity to study that particular piece, take a crack at it, and address some things along the lines that you are talking about.

It seems to me that one of the important points we have to focus on is to do the kind of targeting that you are speaking about. We have got to make the poorer States, the poorer record States, the poorer performance States, look like the better performance States.

So what are the things that the better States are doing in the area of State flexibility and some of the things that they are doing that the other States are not? That is precisely what we are trying to do, to provide the incentives. Let's face it, you and I know that we have to provide incentives by dollars, by providing a structure in which more dollars can be achieved and be realized by a State for better performance.

Let me just tell you, for example, in the non-AFDC area: The ratio of non-AFDC collections to total administrative costs—in other words, the ratio of the collections to total administrative costs—in the 10 States with the best record was $3.46 to $1, compared to $0.16 in the States with the worst record—the 10 States with the worst record.

Now, this is a program with enormous wide swings of performance.

Senator LONG. All right.

Mr. DONNELLY. Now, how do we change that around?

Senator LONG. I am for achieving exactly that. I want to achieve that.

I also know this: If I go all the way with you, and you go all the way with me, where we are agreeing on what the objective is, by the time we get it over to the House of Representatives, we are going to run into some tough opposition over there; we are going to run into a guy like Charlie Rangel over there on the House side who is an influential Member who comes from New York; we are going to run into a fellow named Pete Stark over there who comes from out there in California. And those fellows are not going to be the least bit sympathetic to what we are trying to do about that matter.

Mr. DONNELLY. That is correct.

Senator LONG. And they will try to force us to make some kind of compromise. I don't want to compromise, but if we can't work anything else out we've got to come to terms with those men. It may not be within my power to make New York and California do in child support what I would like to see them do.

All right, now. I wish I could, but I just may not have that much influence. If we can't get them to agree, the logical compromise is to say, "Well, look. At a minimum, if you people are not going to make your own fellows support their children, how about at least sending back to Louisiana fathers who went to your State to try to get away from supporting their children?

But I am concerned that we are not targeting the specific items that we really need to get results. We need to get the fathers of these children identified, and we need to make these States cooperate. If they don't want to make their delinquent parents comply, at least they can cooperate in helping us to make our fathers comply.

Bill Galvin is sitting there in the back of this room. He is known to you and other people in your program. One time Bill was working for your Department, under a previous name—that is, the Department had a previous name at the time. [Laughter.]

And Bill asked a State to bring some fellow back and to make him support his children. When he came back, Bill found out he had the wrong guy after he got here. We want to identify those fathers so we know who we are going after. I have worked awfully hard to improve our ability to do that.

I just hope you will help us to see that in these are for example, this particular area of establishing paternity, the IV-D program, shouldn't be judged how the welfare program is doing it; ought to be judged by how the child support program is doing.

Mr. **Donnelly**. Exactly.

Senator **Long**. These poor IV-D people, for example, do the best they can, and they have been treated like the ugly duckling in many of these State departments. They shouldn't be judged by the poor performance record of some other part of the operation in the State.

I see you are nodding. I hope you can agree with that philosophy.

Mr. **Donnelly**. Senator, I hope you will find, and I think you will—I really feel this—that, as we forge our way through the precise proposals, when we are able to deal with them in markup and before you and in sessions in this committee, you will find we are addressing precisely your concerns, because I sure want you on our side when we go to conference with those other folks.

Senator **Long**. Well, I want to help those who are charged with the duty of collecting support. They tell me that some of these men and women do that at the risk of their lives. You know, a guy might need a bulletproof vest and a bodyguard to go and approach some of those fathers they are trying to get at.

But we need to have the people to do the job and we need to support them. I would be glad to make a donation right now to provide annual awards to those who go out to track these fellows down and pursue them. Maybe we should include an award to those judges that have the good judgment and the courage to put those people in jail until they make the payments the owe.

Now, these are the kind of things we ought to be doing. We should make these fathers pay support when they are in a position to do so. We should put people to work when it is possible to subsidize them into a job rather than to pay them for doing nothing. In these ways we can reduce the burden of the welfare program and do a lot more good for the public. And that's what you had testified for, isn't it?

Mr. **Donnelly**. That is correct.

Senator **Long**. Thank you very much.

Mr. **Donnelly**. Thank you, Senator.

Senator **Long**. I have some other questions I would like to submit, Mr. Chairman.

Senator **Durenberger**. All right.

[Senator Long's questions and the answers from Mr. Donnelly follow:]

*Question.* The Administration budget proposal is to repeal the assured 70 percent Federal matching of child support costs and also the incentive payments provisions. It would substitute a system under which States would primarily cover their expenses out of their AFDC collections.

Isn't the problem the fact that some States have been reluctant to get strongly into this program? Aren't we likely to make them even more reluctant if we eliminate the assured generous Federal matching provisions?

If States must use their AFDC savings to meet their child support administration costs, this means that they can recoup costs of collections only for families on welfare. Won't they then tend to ignore the statutory requirements that they provide services to mothers not on welfare?

Answer. These questions refer, in part, to a funding concept which is not part of legislative proposals actually advanced by the Administration. The Administration's current proposal would decrease the 70 percent Federal matching rate for State administrative costs to 60 percent and shift the savings to a bonus pool. Performance awards, will be paid to States from this bonus pool based on their performance.

The problem today is not that some States have been reluctant to get strongly into the Child Support Enforcement Program. Rather, it is that most Federal dollars are paid out based on what States spend, not the result they achieve. State programs vary widely in their effectiveness and efficiency. The assurance of generous Federal financing acts, in some respects, as an inducement to the perpetuation of marginal performance in providing services to welfare and non-welfare families alike. In times of fiscal constraint, it encourages a transfer of ongoing administrative costs heretofore borne by State or local government to the Federal government without any associated increase in child support enforcement services or collections.

The Administration proposal, on the other hand, is intended to encourage better program performance by regarding those States that establish superior records in serving welfare and non-welfare families. For fiscal year 1984, an estimated $200 million would be available for performance recognition awards, to be paid to States based equally on their AFDC and non-AFDC performance.

Under current law, at State option, a collection fee may be imposed against either the absent parent or taken from the collection itself with regard to non-welfare cases. The Administration is proposing to require an application fee and, in certain circumstances, a collection fee for non-AFDC services, with the latter fee to come from the absent parent when support payments are overdue. The proceeds from any such fees serve as an offset to State administrative costs.

Overall, rather than weaking the provision of services to mothers not on welfare, the Administration's proposals to link performance and funding and to require the adoption of proven enforcement techniques, among other features should significantly strengthen child support enforcement services on behalf of the non-AFDC population.

*Question.* One of the major objectives of the child support program is to help children establish who their fathers are. This is the necessary first step to assure that a child can get the support that is due him and that he will not have to become dependent on the taxpayer.

Out of the total child support administrative expenditures, how much is spent on establishing paternity? Also, how much is spent on locating absent parents, and of the amount spent on parent location services how much is spent in instances where paternity has not yet been established? Could you provide this information on a State-by-State bases?

Answer. As an outgrowth of congressional and Executive Branch concern over the burden of Federal reporting requirements and the ensuing Paperwork Reduction Act of 1980, the Office of Child Support Enforcement ceased collecting administrative cost data by functional area, such as paternity establishment, after fiscal year 1981. It is therefore not possible to provide the actual expenditures requested on either an aggregate or a State-by-State basis.

From 1976 to 1982, the paternity of approximately 802,089 children was established under the Child Support Enforcement Program. Sample data for fiscal year 1981 show 19.32 percent of the total administrative expenditures for that year were spent to establish paternity. The sample uses reported data from the 12 largest States that account for over 60 percent of total annual expenditures. Based on this, we have estimated that $99.02 million was spent in 1981 to establish paternity.

In fiscal year 1982, some 233,000 requests were processed for absent parent location information. Discrete costs are not available.

*Question.* Present law has generous Federal funding as an incentive to State participation. Yet some States apparently have not been very interested in taking advantage of that matching. The law also imposes a penalty for States that do not have effective programs which meet Federal standards. Is it correct that that penalty has never been imposed? Could you explain why it has not been imposed? Can you suggest ways to change that penalty to make it effective?

Answer. No State has been penalized to date. Since 1980, Congress has repeatedly enacted legislation postponing any implementation of the penalty provision whenever it appeared that, in fact, a State might be penalized for noncompliance with Title IV–D requirements.

There are two problems with the current penalty, which would disallow 5 percent of the Federal share of AFDC payments when a State is out of compliance. First, it is quite severe. Second, it is inflexible in that it is based on State compliance with procedures, rather than effectiveness of the program. For example, States running effective and efficient programs may be technically out of compliance with all procedures. Or, a State may have been out of compliance with the early years of the program, but substantially improved in more recent years.

As part of the "Child Support Enforcement Amendments of 1983", the Administration has proposed major modifications to the penalty and associated audit provisions of present law. Our intent is to focus much more on examining program performance and results achieved rather than just procedural compliance. Corrective action rather than a punitive approach would be stressed. And, to this end, a graduated penalty rather than a flat five percent is proposed. The graduated penalty would be applied only after a period allowed for corrective action in which no improvement was made. We believe that this approach will make the penalty provision truly meaningful and a stimulus to program improvement.

*Question.* The Social Security Act lists 10 duties that the Federal child support administrator is responsible for in connection with the child support program. The number one duty is this: Establish such standards for State programs for locating absent parents, establishing paternity, and obtaining child support—as he determines to be necessary to assure that such programs will be effective.

Could you generally discuss how successful you have been in carrying out this obligation to set performance standards which assure effective State programs? Could you describe in general terms what a State has to accomplish to show you that it is effective in each of these areas: (a) Total collections; (b) service to non-welfare families; (c) cooperation with other States; and (d) establishing paternity.

A. The Department first published regulations establishing standards for program operations in June, 1975. Since then, these regulations have been periodically amended to revise, clarify, and simplify the standards. A State IV–D program is generally considered to be effective in total collections if it is collecting more support than it is expending under the program. Services to non-welfare families are effective if the State has written procedures and is utilizing them to provide on a Statewide basis all appropriate child support services available under the State plan, including locating absent parents, establishing paternity and securing child support. Effective cooperation with other States generally requires the IV–D agency to utilize the same remedies normally available to its own cases to those of another State in locating absent parents, establishing paternity, processing and enforcing court orders, and collecting any support payments from the absent parent and forwarding them to the State to whom they are owed. The State IV–D program is effective in the establishment of paternity if, for cases referred by the IV–D agency or received by application, the IV–D agency has attempted to establish paternity by court order or other legal process under State law or by acknowledgement if, in a given State, it has the same effect as court-ordered paternity.

Since November 1981 the Department has been developing specific performance measures for evaluating State IV–D programs. Proposed performance measures and audit criteria for evaluating program effectiveness are expected to be disseminated to interested individuals and appropriate governmental agencies by the end of this fiscal year.

*Question.* The title of part IV-D of the Social Security Act is "Child Support and Establishment of Paternity." Although Paternity Establishment is expensive and may not seem to be cost effective in a short-range sense, it is a fundamental element in securing a child's right to parental support throughout all the years until he is an adult. Does the Department have an active program of assuring that States are fulfilling their responsibility to have effective programs for establishing paternity? Can you suggest any things that can be done to improve the performance of the States in this area?

Answer. OCSE has offered and continues to offer training courses under the National Institute for Child Support Enforcement related to the establishment of paternity. In addition, numerous publications and instructions have been disseminated by OCSE regarding the various aspects of paternity establishment. These continue to be available upon request from the National Child Support Enforcement Reference Center.

OSCE recently published for comment regulations to ensure that IV-D cases needing paternity establishment are given appropriate emphasis when States are determining their IV-D caseload prioritizations.

OCSE is currently funding the following Research and Demonstration projects dealing with various aspects of paternity establishment; the results of these studies will be disseminated to all State IV-D agencies, and should provide valuable assistance in the improvement of State paternity establishment programs.

"An Investigation Into Practical Aspects of Modern Paternity Testing" is examining the effects of changes in assumptions and gene frequencies on the probability of paternity. It is also attempting to determine easier and more accurate methods of calculating the probability of paternity.

Two "Costs and Benefits of Paternity Establishment" grants are investigating methods of lowering the costs of the paternity establishment process, as well as attempting to quantify the long-term benefits of early paternity establishment. One grantee is focusing on the scientific aspects of blood testing, while the other is concentrating on the administrative and legal aspects of such procedures.

"Development of Standards for Parentage Testing Laboratories," which will be awarded later this fiscal year, will develop acceptable laboratory standards for genetic parentage test procedures and for the certification of laboratories which wish to conduct IV-D related parentage tests for Federal reimbursement. The grantee will then begin to actually certify such laboratories.

*Question.* In setting up the Federal support law, we required that there be a separate Federal agency with this responsibility and that there also be a separate agency in each State. Congress felt that an agency whose only function was administering one program would give it high priority and would be more effective than if the program was buried in a larger agency which might conisider its other jobs more important. Apparently, this approach has proven generally successful at the Federal level and in a number of States. But there are reportedly some States in which the child support agency has little ability to monitor and control the operation of State child support enforcement programs. Is it your understanding that this is a problem? What do you think might be done to remedy it?

Answer. In some areas, support enforcement legislation in minimal and program administrators of parent agencies do not place high priority on the program. Numerous child support enforcement agencies are a part of much larger social service departments. Frequently the IV-D agencies do not receive adequate support from budgetary, personnel, and automated systems components of State governments. High level commitments by Governments and their staff, Cabinet officials, and program administrators is necessary in some jurisdictions to substantially improve the program.

The Secretary is committed to focusing more attention on the problem of non-support by absent parents and assisting State child support enforcement agencies in receiving the appropriate attention and commitment.

Last January, the Director of the program sent a letter to all the Governors encouraging them to give priority to child support endorsement. OCSE's regional offices have also assisted State IV-D agencies when significant impairment would be caused by certain administrative decisions.

*Question.* The Administration proposes to require States to have an administrative procedure for establishing and enforcing support. It is not entirely clear just what that means. Some States now have an entirely judicial system. Can you describe just how much of a change a State would have to make to come into compliance with the administrative method you are proposing?

Answer. Our proposal mandates State use of an administrative or quasi-judicial procedure, or a combination thereof, organizationally established at their discretion; e.g., on the prosecuting attorney's office, the IV-D agency, a separate State hearing office, etc. An administrative procedure for child support enforcement entails a hearing before an administrative hearing officer who has been empowered by the State to order support and whose orders are, therefore, legally enforceable. The obligor is entitled to have his attorney present and, if he wishes, to ask for judicial review of any order for support made by the administrative hearing. A quasi-judicial procedure can be one of two types—a voluntarily agreed upon support amount between the absent parent and the child support agency which is subsequently signed by a judge without a court appearance by the absent parent—or an appearance before a referee or court master who makes a recommendation to a judge on the amount of support to be paid. The judge, who normally agrees to the recommendation, then signs the order without another appearance by the absent parent.

These procedures are quicker and cheaper than the judicial system. They also tend to produce higher support amounts than the judicial system.

It should be noted that our proposal provides authority for the Secretary to waive these requirements if a State or locality can show that its current system is equally effective.

*Question.* It is my understanding that one problem with achieving an effective child support program in some States is that the welfare agencies still are not very cooperative. Do you know if this is in fact a problem and can you suggest any ways that we might address that situation?

Answer. This is a problem in some States. An in-house analysis is now being conducted with the intention of improving cooperation. We are attempting to identify model State agency cooperative arrangements, identify and establish cooperative performance indicators, and evaluate effective practices to facilitate cooperation among States. The effort should be completed by October-November of this year and we will be happy to share the results with you.

*Question.* The Administration is proposing to mandate some new procedural requirements on the States such as wage garnishment and administrative procedures. Other people are proposing still more new State mandates. Is this really getting at the heart of the problem? Is it your experience that some States have these kinds of procedures on the books but still do an ineffective job? If so, what would you see as the central problem that needs to be addressed?

Answer. We believe that the heart of the problem is the current method of funding. The State mandates are the part of the package which will give the inefficent States three excellent and proven tools that will help them to qualify for performance awards. While it is true that some States provide for the procedures not all of them use them. Our proposals to place more emphasis on performance and to establish audit criteria based on performance, rather than "blank check" funding and procedural compliance, will require States to have and utilize these efficient and effective enforcement procedures. In addition, States will have incentives to increase their performance awards and avoid the potential penalty for operating an ineffective program.

*Question.* What would be the estimated caseload of the State clearninghouse in the first year of operation? The fifth year?

Answer. We estimate for fiscal year 1985 the caseload for the State clearinghouses would be 10.2 million in conjunction with the revised statement of purpose for the program proposed in the Economic Equity Act which would incorporate all children entitled to support, as IV-D cases. The caseload for fiscal year 1989 is estimated to be 15.3 million under the Economic Equity Act.

*Question.* What would be the cost of services to the additional caseload (assuming the average cost of services now provided to non-AFDC recipients, adjusted for inflation) in the first year of operation? The fifth year?

Answer. Assuming an additional 1 million non-AFDC cases in 1985, the estimated additional cost of providing all CSE services to these families would be approximately $89 million. In 1989, an additional $335 million would be required to provide services for an estimated 3.1 million additional cases. Federal government costs would be $62 million and $234 million respectively, based on the current 70 percent Federal match.

*Question.* Are there any court challenges on the use of the IRS tax refund offset mechanism which might have implications for the use of this mechanism for non-AFDC families?

Answer. There are approximately 20 cases challenging the IRS tax refund offset mechanism on due process and other grounds. Accurate documentation of past-due support amounts before involving the Federal income tax system to intercept tax refunds to pay past-due support is of major importance. The major operational barrier to use of the IRS tax refund intercept process for non-AFDC families is the current difficulty in documenting accurately amounts of past-due support.

Senator DURENBERGER. I wonder if Bill Galvin would stand up and identify himself. [Laughter.]

Mr. DONNELLY. Under a previous name. [Laughter.]

Senator DURENBERGER. Tom, before you leave—oh, there he is. Oh, of course—that Bill Galvin. [Laughter.]

I am concerned—just one simple question about your restructuring formula. This gets back to Senator Long's question about how successful we can be on collecting non-AFDC collection.

I understand your formula uses administrative costs for both non-AFDC and AFDC, but only collections for AFDC. Is that a fact, and if so what can you do to change it?

Mr. DONNELLY. We are finalizing that formula, Senator. As you know, the bill isn't up here yet, and we have heard some concerns that have been expressed, and the Secretary has paid particular attention to some of those concerns. So those decisions are not final, but they will be within the next day or two.

Senator **Durenberger**. All right. Thank you very much. We appreciate your testimony, and your questions, Senator.

The next panel will consist of Mr. Dan R. Copeland, Alaska State child support director, and president of the National Council of State Child Support Enforcement Administrators, from Anchorage, Alaska; Mr. John P. Abbott Utah State child support director, Salt Lake City, Utah, and chairman of the Subcommittee on Child Support, National Council of Public Welfare Administrators, Washington, D.C. and Ms. Betty Hummel, Kansas State child support director, Topeka, Kans., and chair, legislative committee, National Reciprocal Family Support Enforcement Association, Des Moines, Iowa.

I welcome all three of you to the hearing. Your statements will be made a part of the record, and I would encourage you to summarize them in the time available to us. But that does not mean you are not welcome, and your testimony in full is welcome to this committee.

Are you Dan Copeland?

Mr. **Copeland**. I am, Senator.

Senator **Durenberger**. You may proceed.

## STATEMENT OF DAN R. COPELAND, ALASKA STATE CHILD SUPPORT DIRECTOR: AND PRESIDENT, NATIONAL COUNCIL OF STATE CHILD SUPPORT ENFORCEMENT ADMINISTRATORS, ANCHORAGE, ALASKA

Mr. **Copeland**. Good afternoon. I am Dan Copeland, the president of the National Council of State Child Support Enforcement Administrators. I also serve as the director of the Alaska State Child Support Enforcement Agency. The national council includes the operational head of each State child support agency. As such, this gives each council member a good firsthand working view of the child support program and its total impact on the public entitlement programs.

Each of us recognize that over the years the public entitlement expenditures have increased at an alarming rate. In response to this, the administration, through their current budget proposals, is attempting to redefine what Congress set up to do in 1975 with the original child support legislation. This proposal includes two distinctly different aspects, and they are not related in any manner. However, when presented together, they tend to cover certain policy changes.

At this point, the proposal has not been reduced to legislation but the Federal Office of Child Support Enforcement has explained it in detail to the council.

The first part of the budget proposal, known last year as restructuring and this year as performance funding, redirects the program to the AFDC governmental reimbursement work. The emphasis is on collections which are sent on to the State and Federal Government. Doing collection work for the custodial parent and child—better known as non-AFDC work—is merely tolerated and does not have direct or sufficient funding.

The national council is opposed to the funding proposal. I have included a survey summary of all the 54 States and jurisdictions which indicates that opposition. We have also listed the reasons for our position in that survey.

The proposal is a narrow, shortsighted attempt to fix a long-term problem. There is a transition period that is provided, but the current funding mechanism as the proposal presents it is not changed in any manner.

In addition to the basic policy deficiencies, the proposal has numerous operational defects. To begin with, the term "total collections" is redefined to include only AFDC collections as retained within each State. This will force many States to discourage or significantly reduce their interstate collection work.

Under the proposal, any effort spent on the non-AFDC caseload will tend to have a punitive financial impact. The proposal's non-AFDC $18 million bonus plan, when spread over the 50 States, is not adequate in concept or amount.

Doing the paternity work does not provide for an immediate collection; therefore, under the proposal, doing paternity establishment work will be discouraged. That is probably one of the more important aspects of the program and has maybe one of the more long-term benefits. It would be forced out at that point.

The majority of the collection work comes from the States that are dominated by local and county level operations. This proposal does not allow for the stable funding mechanisms, which is an absolute requirement to county participation.

The second part of the proposal is not a matter of funding but deals with legislation for operational improvements. The council strongly supports these things, like wage assignments, administrative process, and income tax refund intercepts. It is important to recognize that this part of the proposal is separate and totally unrelated to the funding issue. Many of the States already include these types of statutes in their own States and are using them now.

The council recognizes that the child support process appears simple on the surface but in fact it is extremely complicated. To provide an overview from the practitioners, point of view, we have offered a status report as prepared by our organization.

In closing, the council is requesting this committee to consider the extreme defects in the funding proposal and then totally reject this part of the administration's budget proposal.

The issue is fairly simple. Does Congress want the child support program to be a child support service or a governmental source of revenue? The national council is committed to doing both, while we feel the administration's proposal is an attempt to limit our efforts to the governmental reimbursement work.

I would like to ask you to reject this narrow concept.

Also, if I could, the statistics that were quoted to you all we are a little concerned with, because quite often they reflect performance under the direction that this proposal is attempting to take, and all of the statistics are generally referred to in the distributed AFDC work.

Senator DURENBERGER. All right, thank you very much.

[The prepared statement of Dan R. Copeland follows:]

## STATEMENT OF DAN R. COPELAND, PRESIDENT, NATIONAL COUNCIL OF STATE CHILD SUPPORT ENFORCEMENT ADMINISTRATORS

Good afternoon, I am Dan R. Copeland, President of the National Council of State Child Support Enforcement Administrators. I also serve as the Director of the Alaska State Child Support agency. The National Council includes the operational head of each state Child Support agency. The Council members get a first hand working view of the child support program and its impact on public entitlements.

Each of us recognize that over the years the public entitlement expenditures have increased at an alarming rate. In response to this, the Administration, through their current budget proposal, is attempting to redefine what Congress set up in 1975 with the original Child Support Legislation. This proposal includes two distinctly different sections which are not related in any manner. However, they are presented together and this tends to cover certain policy changes.

At this point, the proposal has not been reduced to legislation but the Federal Office of Child Support Enforcement has explained it to the Council. The first part of the budget proposal, known last year as restructuring and known this year as performance funding, redirects the program to the AFDC governmental reimbursement work. The emphasis is on collections which are sent on to the state and federal government. Doing collection work for the custodial parent and child or non-AFDC work is merely tolerated and does not have direct or sufficient funding.

The National Council is opposed to the funding proposal. I have included a survey summary clearly indicating that opposition. The reasons for opposition are also summarized.

The proposal is narrow and shortsighted in light of the long term problem. A transition period from the current funding mechanism is offered but that does not alter the proposal's basic premise.

In addition to the basic policy deficiencies, the proposal has numerous operational defects. To begin with, the term "total collections" is redefined to include only AFDC collections as retained within each state. This will force many states to discourage or significantly reduce their interstate work. Under the proposal, any effort spent on the non-AFDC caseload will have a punitive financial impact. The proposal's non-AFDC 18 million dollar bonus payments, when spread over 50 states, is not adequate in concept or amount.

Doing paternity establishment work does not produce an immediate collection. Under this proposal the states will be forced to reduce the paternity work. The majority of collections come from states that are dominated by local or county level operations. The proposal does not allow for stable funding which is essential to county participation.

The second part of the proposal is not a matter of funding but deals with legislation for operational improvements like wage assignments, administrative process and income tax refund intercepts. It is important to recognize that this part of the proposal is separate and totally unrelated to the funding issue. Many of the states are already working on the same type of improvements in their own state.

The Council recognizes that the Child Support process appears simple on the surface but in fact it is extremely complicated. To provide an overview from the practitioners' point of view the attached Status Report is offered for general review.

In closing, the Council is requesting this committee to consider the extreme defects in the funding proposal and then totally reject this part of the Administration's budget presentation.

The issue is fairly simple. Does Congress want the Child Support Program to be a Child Support service or source of government revenue. The National Council is committed to doing both. The Administration's proposal is an attempt to limit our efforts to the governmental reimbursement work.

Please reject this narrow concept.

# THE CHILD SUPPORT ENFORCEMENT PROGRAM
## A STATUS REPORT - FEBRUARY, 1983

## EXECUTIVE SUMMARY

The National Council of State Child Support Enforcement Administrators has prepared this report to present its views regarding the support enforcement problem that exists for the many children affected by divorce, separation, or the lack of established paternity. A brief history has been included to aid the reader in understanding the scope of the problem and the program accomplishments. Recommendations for the future of the program must include the establishment of a national ethic that children have a right to be supported by both parents. The need is basic . . . children need their child support!

It is important for the reader to understand that practitioners in the field of support enforcement believe that the wrong approach has been used in the attempt to address the issue of poverty among children. Although well meaning, the vast network of social legislation addresses the symptom of the problem rather than the cause. The system provided welfare first, and later as an afterthought . . . child support enforcement. This course of action was taken in spite of the fact that at least 80% of the reasons for eligibility for Aid to Families with Dependent Children (AFDC) has been insufficient child support from the absent parent.

It is obvious to practitioners that if the national effort to try to fix the AFDC and other related welfare programs had instead been invested in curing the disease (lack of support), the nation would not be paying an estimated $30 billion annually for public entitlements. The primary reason for the 30 billion dollar problem was and still is caused by the lack of child support. The problem is not isolated to children receiving public assistance. Regardless of the income level, millions of America's children are being economically deprived and cannot achieve true potential if financial support is withheld by one or both parents.

In 1975, when Congress established the Child Support Program (Title IV-D of the Social Security Act), the establishment of a comprehensive support enforcement system was envisioned. In mandating states to provide AFDC and non-AFDC related services, it appeared the purpose of the program was to provide an opportunity for all children to receive support from their parents through more effective enforcement of state and federal child support laws. While the primary objective was to directly reduce the increasing burden on the taxpayer of maintaining the AFDC program, the law also required states to provide child support enforcement services for all applicants that were not in the AFDC program.

Child support practitioners are of the opinion that the program's focus from the federal perspective has changed. Instead of encouraging states to collect child support for children, AFDC collections for governmental reimbursements are now emphasized. The law created two programs to address the one issue of non-payment of child support. However, the federal government began to concentrate more than ever on the public assistance aspect of the Child Support Program by consistently recognizing only the AFDC related accomplishments. Faced with this situation, states are placed in a position of either following the letter of the law while ignoring the operational directives of the federal government, or deemphasizing regulatory requirements to adhere to the federal directives.

Actual collection history indicates that states vary considerably in their approach to the two services. Some states concentrate on AFDC collections while others focus on non-AFDC services. In FY 81, the program collected $1,628,894,466 at a cost of $512,517,943. This 3.18 to 1.00 ratio is obviously successful. A total of $958,256,541 was collected in the non-AFDC portion of the program and $670,637,925 in the AFDC portion.

Several studies done by individual states indicate that the non-AFDC child support program is responsible for saving millions of dollars each year in welfare costs avoided. The non-AFDC portion of the program encourages independent child support payments. This reduces the need for governmental dependency while helping to curtail financial deprivation in general. Federal law allows states, at their option, to charge a fee for these services. However, fees are not universally charged and experience has shown that when they are, they do not cover the cost of the non-AFDC portion of the program.

Decision makers need to realize that both portions of the program are cost effective and vitally important. Sufficient funding must be retained to adequately address both AFDC and non-AFDC child support cases. The establishment of paternity, interstate collections, and the many facets of the total problem of child support enforcement are common to both caseloads. In the final analysis, there is no substantial difference; it is a matter of children and their right to be supported by their parents. Decision makers need to redirect their priorities to address this vital root cause of poverty among children. Both parents, not governmental aid programs, need to be responsible for their children. The current Child Support Program is in the infant stage of returning this responsibility of all children to the parents.

## HISTORICAL PERSPECTIVE

The first question to be answered was, "Whose obligation is it to support children?". Common law has historically failed to impose on absent parents a civil obligation to support their children. Although custody of children has traditionally been given to the mother, and the absent parent was the father, common law had not expanded much past that point. As late as 1953, the Supreme Court of New Jersey had difficulty finding a legally enforceable support obligation which bound the father to his children. The need was so basic -- but the remedy only referenced "natural law."

Viewed as a state and local problem for many years, federal attention was attracted as costs in the Aid to Families with Dependent Children (AFDC) program continued to escalate. Inadequate laws and a lack of funding were producing low child support collections while over 80% of those receiving AFDC were eligible due to the non-payment or insufficient payment of child support obligations. Contributing to the problem was the prevailing attitude that government, rather than the absent parent, should support abandoned children by means of the AFDC program. Unfortunately, this gave more credence to the concept that it was the custodial parent's responsibility (usually the mother's) to support the children. Due to the social acceptance of this trend, thousands of single parent families (even those not reliant on AFDC benefits) were left without a viable means of support.

To address this problem, Senator Russell Long, then Chairman of the Senate Finance Committee, and Representative Martha Griffith, then Chairwoman of the Subcommittee on Fiscal Policy of the Joint Economic Committee, developed and published an analysis of the welfare system. Both were dedicated to improvement of child support enforcement laws and practices. Changing social mores and the complexity of the problem helped to convince Congress to relieve the plight of the single parent by creating a federal office with oversight responsibility; the Office of Child Support Enforcement, (OCSE) was created effective August 1, 1975. The Title IV-D amendments to the Social Security Act created a funding mechanism to address this chronic national problem.

In their deliberations on the creation of the Federal Child Support Enforcement Program, the Senate Finance Committee stated:

> "The Committee believes that all children have the right to receive support from their fathers. The Committee bill, like the identical provision (H.R. 3153) is designed to help children attain this right, including the right to have their fathers identified so that support can be obtained. The immediate result will be a lower welfare cost to the taxpayer but, more importantly, as an effective support collection system is established fathers will be deterred from deserting their families to welfare and children will be spared the effects of family breakup." (Emphasis added).

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## Federal Involvement Was Necessary

Since the late 1950's, the number of single parent families has increased dramatically. That growth is directly attributable to the escalating numbers of divorce, marital separation and out-of-wedlock births. Then as well as now, the custodial parent, usually the mother, faced with a financial crisis often seeks financial assistance through governmental outlets. Since most heads of single parent households enter the work force at an inadequate wage level, they find their incomes insufficient to meet ordinary household expenses, day care, clothing and the transportation expenses related to working. The combination of the burdens of daily work, which provides an inadequate income, and the complete responsibility for rearing the children, often overwhelms the custodial parent. These factors, coupled with the lack of financial support from the absent parent, often place the custodial parent in a position of financial dependency upon governmental programs.

Current national estimates indicate one out of every three marriages in the United States ends in divorce. There is an obvious correlation between the increasing divorce rate and the increase in the number of welfare families with single parents heading the household. Seventy-eight percent of all welfare households consist of a single parent, usually a woman, who is providing the basic needs for her family through an assistance grant because the father withdrew or never provided financial support. When absent parents default and avoid their financial responsibilities, the chance of their children being supported by a governmental aid program is much higher. A study presented to the Senate Finance Committee by M. Winston and T. Forsher, "Non-Support of Legitimate Children by Affluent Fathers as a Cause of Poverty and Welfare Dependence", stated that non-support of legitimate children by affluent fathers was often a cause of poverty and welfare dependence. Another conclusion in the study was that many attorneys and public officials found child support issues boring and in some instances were even hostile to the concept of fathers being responsible for their children.

## The Scope of the Non-support Problem

How serious is this problem of non-support of families by absent parents? Over seven million children are presently receiving public assistance in the United States through the various federal and state welfare programs. Of greater concern is the possibility that the very existence of the welfare program has caused some of the absent parents to conclude that if they have marital difficulties, they need not worry about the consequences of financially abandoning their families. From their perspective, the government will provide assistance for their children while they establish new lifestyles and often become parents of more children.

The number of children in single parent households is growing at a rapid rate. The 1970 census figures showed 8,265,500 children living with only one parent. By 1980, the number had grown to 12,163,600, nearly a 50% increase! The problem from a financial perspective is that nationally less than half of these custodial parents received the money due to them.

In the early stages of the welfare program, little was done to recoup the welfare dollars expended. As a result of this lack of action, many absent parents who may have been capable of paying became remiss in their obligation to support their children. For a considerable period of time, they were not made to bear the costs of supporting their children. Society simply "picked up the tab." The cost of the tab, however, has become incredible. In 1956, the total cash benefits expended in assistance to children was just over $617 million. By 1982, that figure increased to an astounding $12 billion annually -- a 2000% increase in 22 years. As staggering as that figure may be, it is not all inclusive. Additional billions were spent on food stamps, medicaid benefits, foster care, juvenile institutions, and other related programs.

## THE CHILD SUPPORT ENFORCEMENT (IV-D) PROGRAM

Because of the immensity of the problem, in 1975 Congress enacted Public Law 93-647. Maintaining a child support program became an individual state eligibility requirement to receive federal match funding in Aid to Families with Dependent Children (AFDC). The Federal Office of Child Support Enforcement (OCSE) promulgated regulations covering the maintenance of case records, the establishment of paternity, the locating of absent parents, the enforcement of support, and the use of cooperative agreements among the states. The administration of the program was left to the state child support units, which are required to function within the parameters of federal regulations, local and state laws, county, and/or judicial prerogatives.

Originally, federal financial participation provided for 75% of the administrative costs of operating a child support program. The remaining 25% was provided by the state and or local government. With the 1982 changes in federal law, effective 10/1/82 financial participation is now a 70% - 30% split.

To encourage cooperation between states, local governments, other political jurisdictions, and to increase AFDC collections, the federal government also provided for a 15% incentive payment on AFDC collections. This 15% payment is deducted from the federal share of the AFDC distribution. However, the 1982 legislation provides that as of October 1, 1983, the 15% payment rate will be reduced to 12%. Lowering the incentive percentage rate will actually provide a disincentive to state programs.

A financial commitment is necessary to begin reversing the trend toward lack of cooperation between states that has developed. Continued and expanded support at the national level will result in future growth and success in the program. At the same time, the individual families will move toward less dependence upon the federal and state government for financial support.

There are two categories of cases; AFDC and non-AFDC. For children receiving AFDC, collections are distributed back to the state and federal governments. These collections are distributed between the two based upon the matching grant rate which the federal government provides to each state for their medicaid and AFDC programs. For families who are not receiving AFDC, collections are sent directly to the custodial parent. Neither the state nor the federal government receives any portion of non-AFDC collections (except fees), but both directly benefit because the collections do significantly reduce the potential for AFDC eligibility.

In FY 81, 1.6 billion dollars in child support payments were recovered from absent parents. This recovery effort represents a step in the right direction, but many barriers still exist which inhibit effective and efficient child support collections. The major barriers have been the lack of enforceable laws and resources to handle the immense nature of the problem. The difficulty is compounded by the large number of absent parents who cross state lines in an attempt to avoid payment of support. Nationally, only 11.3% of the absent parents whose children are on welfare are actually paying child support. Reliable data now exists which indicates that this figure can be greatly increased. A number of states are already receiving payments on over 20% of their cases.

The most current information available to the states demonstrates continuous progress in program effectiveness. The data below has been extracted from the 6th Annual Report to Congress, published by the Department of Health and Human Services, Office of Child Support Enforcement.

TABLE I

| | 1976 | 1977 | 1978 | 1979 | 1980 | 1981 |
|---|---|---|---|---|---|---|
| Total Child Support | $512 mil. | $864 mil. | $1,048 mil. | $1,333 mil. | $1,478 mil | $1,629 mil. |
| AFDC Collections | 204 mil. | 423 mil. | 472 mil. | 597 mil. | 603 mil. | 671 mil. |
| Non-AFDC Collections | 308 mil. | 441 mil. | 576 mil. | 736 mil. | 875 mil. | 958 mil. |
| Paternities Estab. | 14,706 | 68,263 | 110,714 | 117,402 | 144,467 | 163,554 |

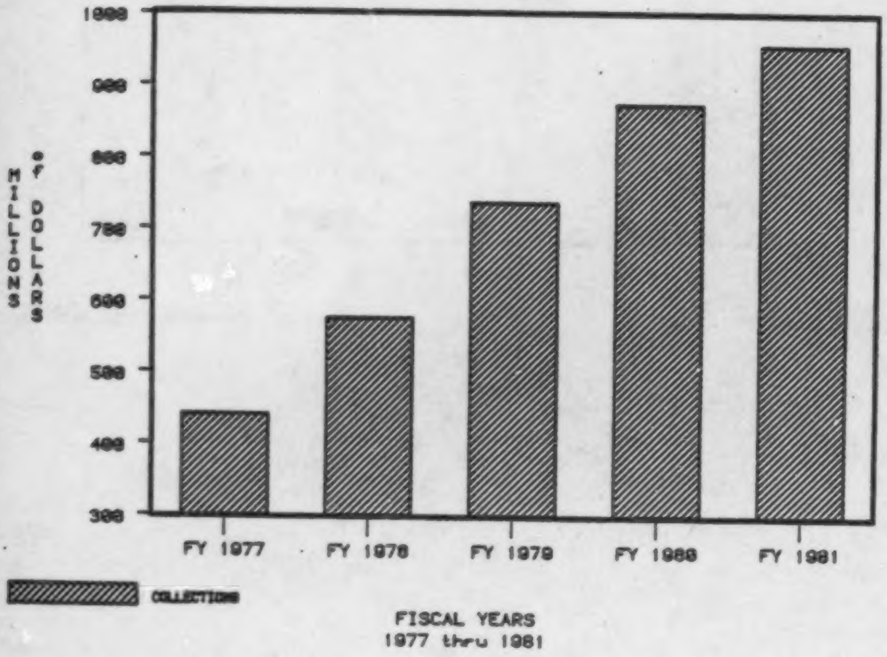
## Non-AFDC Collections

It is worthwhile to note, in reference to the figures on the graph below, that the funds collected in the non-AFDC category are distributed directly to families not on public assistance. Several independent state studies have estimated that 15% to 25% of these families would be on public assistance if the child support collection service were not in place. This translates into substantial savings in AFDC, food stamp, and medical assistance expenditures.

Table II depicts annual collection totals for the non-AFDC portion of the program. Collections increased nearly 117% during the five year reporting span and the effect from this collection effort is a reduction in individuals receiving AFDC assistance. While termed "cost avoidance", the AFDC reduction reflects a substantial savings in all welfare program expenditures. There would be a significant increase in the number of AFDC applicants if the non-AFDC collection program were allowed to diminish.

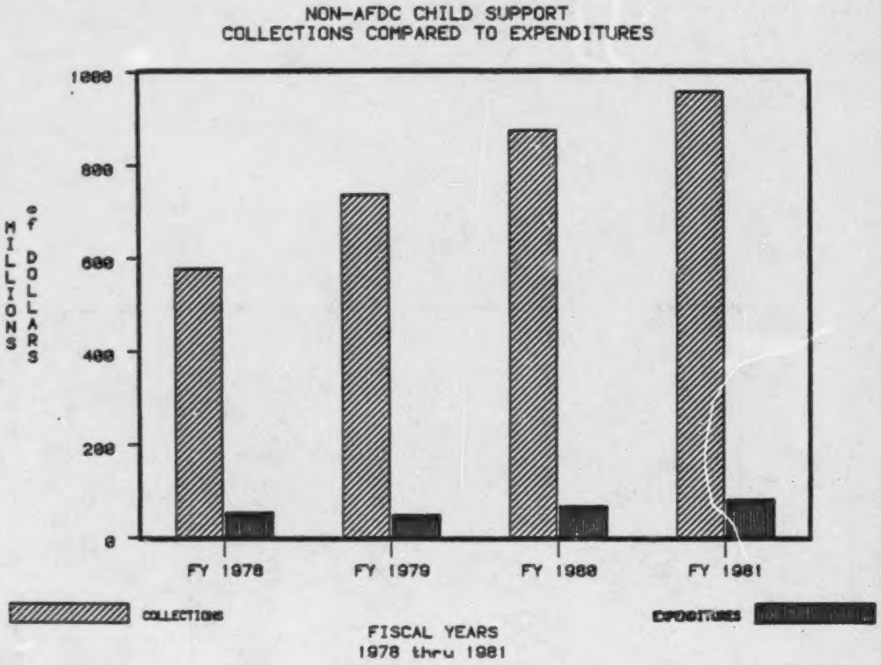
TABLE II

NON-AFDC
COLLECTIONS



Non-AFDC collections indirectly offset the costs of the public assistance program. Table III shows the costs compared to collections in the non-AFDC program. It is significant to note that while the non-AFDC collection total is now one billion dollars annualy, this collection figure has not been used in the evaluation of the program's achievement. On the other hand, the cost of operations has been used as an integral part of the program evaluation. Practitioners are concerned about this and puzzled by the lack of compliance with congressional intent.

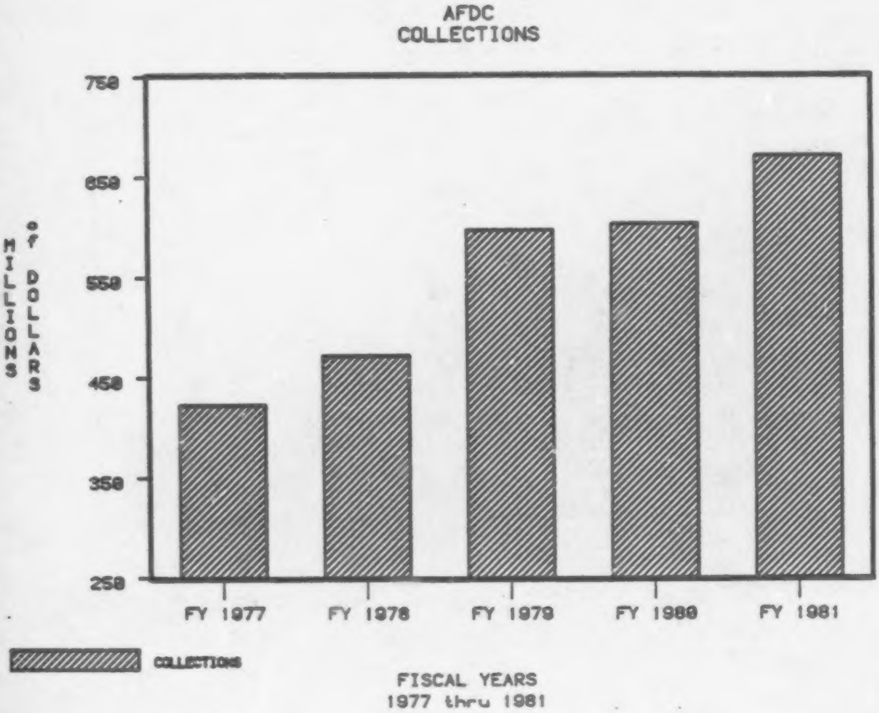
## TABLE III



## AFDC Collections

AFDC collections directly offset the costs of the public assistance programs. Table IV reflects significant annual AFDC collection increases during the periods FY 77 to FY 81. The program has experienced a 59% increase in funds recovered. Favorable legislative action or improved enforcement techniques at the federal, state, and local level, are directly attributable to this trend.

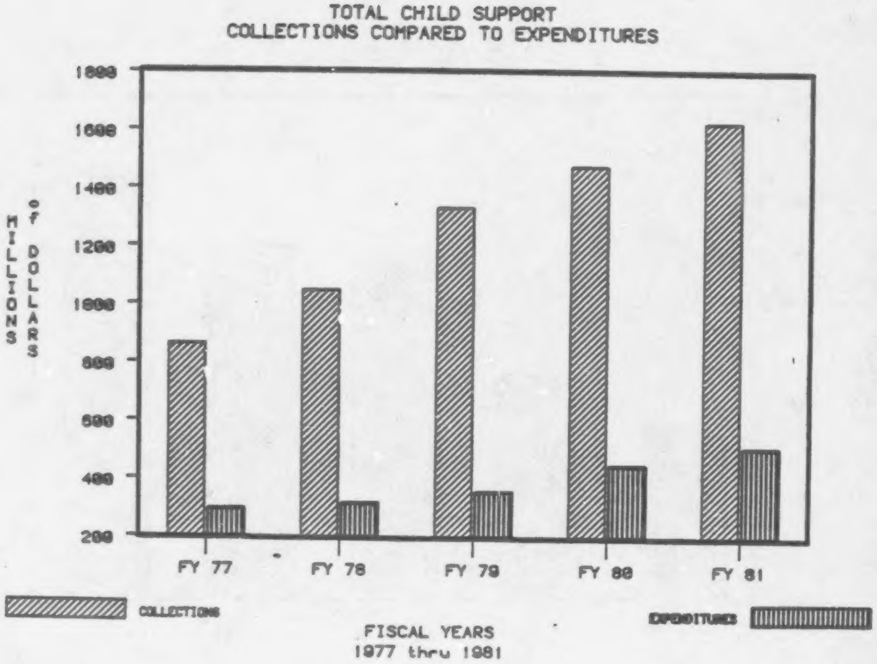
TABLE IV



## AFDC and Non-AFDC Collections

A combined chart (Table V) showing the effectiveness of the AFDC and non-AFDC initiatives provides dramatic illustration of the program's success. This shows the difference between collections and expenses. Clearly, collections are running ahead of expenses by a 3 to 1 ratio. From FY 77 to FY 81, annual collections have increased by more than 750 million dollars, while the corresponding figure for expenses shows an increase of about 200 million.

TABLE V



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## Interstate Collection Difficulties

Due to the Nation's transient population, some states are experiencing a large influx of absent parents. These states are collecting an increasing amount of child support which is sent to another state where the custodial parent and children are living. In many cases there is a considerable difference in the amount that is sent out of state as opposed to what is returned. The local jurisdictions within the states are experiencing similar problems.

The state and local jurisdictions that actively pursue collection work on behalf of others, must deal with a distorted and often negative collection to expenditure ratio. This problem is complicated even further by the lack of uniform laws and legal requirements. It is imperative for the absent parent population to recognize that moving to another state does not eliminate their child support obligation.

Currently OCSE has initiated a contract to the National Institute of Child Support Enforcement (NICSE) to survey and study the interstate collection problem. This will include contact with approximately 10,000 jurisdictions and/or organizations which perform child support services nationwide. Work on this contract will start in early 1983.

## Establishing Paternity

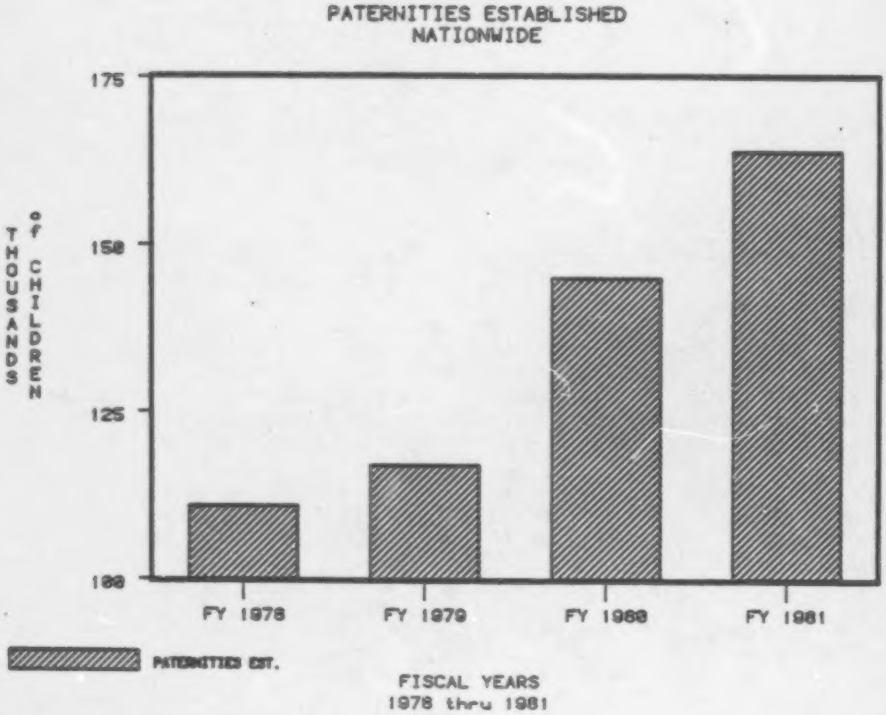
A significant factor which has contributed to the increased growth of the welfare program (AFDC) is the number of children born out-of-wedlock. According to statistics maintained by the National Health Center in 1979, there were an estimated 597,800 out-of-wedlock babies born in America. This was approximately 17% of all births, but is even more striking when compared to statistics of a decade ago. In 1970, unwed mothers had 399,000 babies, or 10.7% of all births for that year. OCSE reports that the large increase in the non-marital birth rate has brought a corresponding increase in the cost of AFDC funding.

The "inherent right" of the child starts with paternity establishment. Legally identifying the father establishes potential Social Security, veteran's assistance benefits, insurance benefits, and potential inheritance rights. It is the first step in shifting the burden of support from a government program back to both parents.

Currently, OCSE has initiated two contracts to study the cost effective aspects of doing paternity establishment. Work on these contracts will start in early 1983.

Table VI indicates a 68% increase in paternity determinations during the four year period ending 1981. This demand for paternity establishment should be paramount in every child support unit, however, the task is extremely expensive. These costs are immediate while the benefits are of a long term nature.

TABLE VI

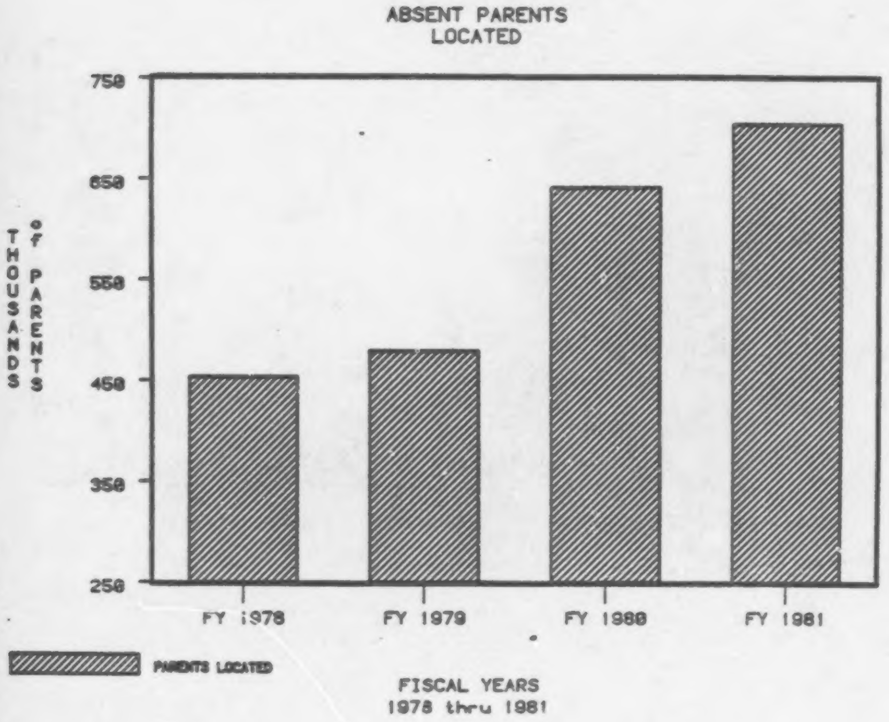


## Locating Absent Parents and Establishing Support Obligations

In order to increase collections during the short history of the program, states have had to work on locating absent parents and establishing support orders.

Before a case can be established as an enforceable order, the absent parent must be located. Table VII indicates the number of absent parents located for the establishment or enforcement of a child support obligation.

TABLE VII



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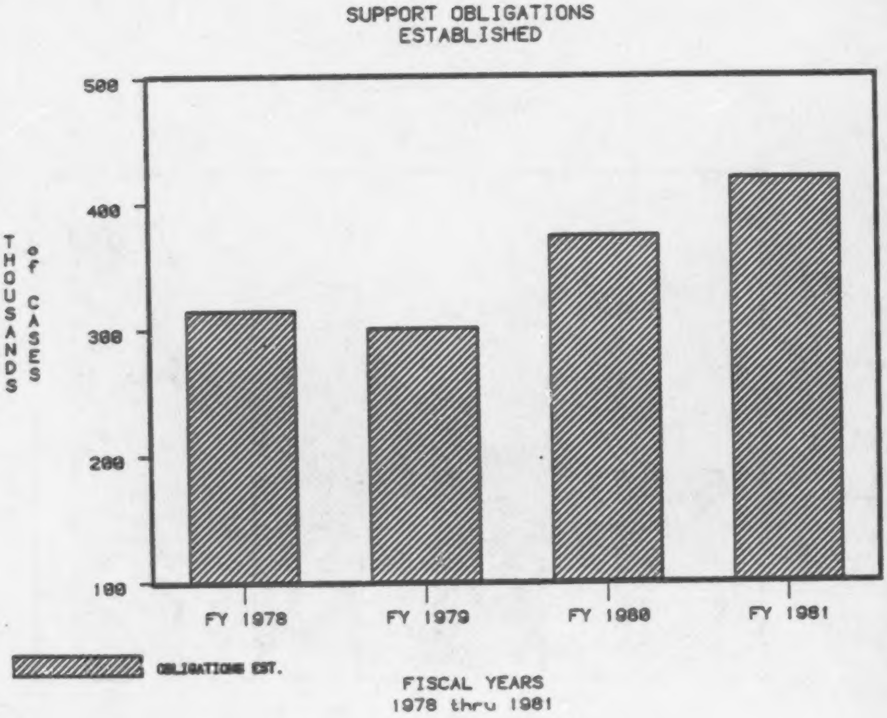
Once the absent parent is located, a legally binding child support obligation must be established. Table VIII indicates the number of obligations that have been established.

TABLE VIII



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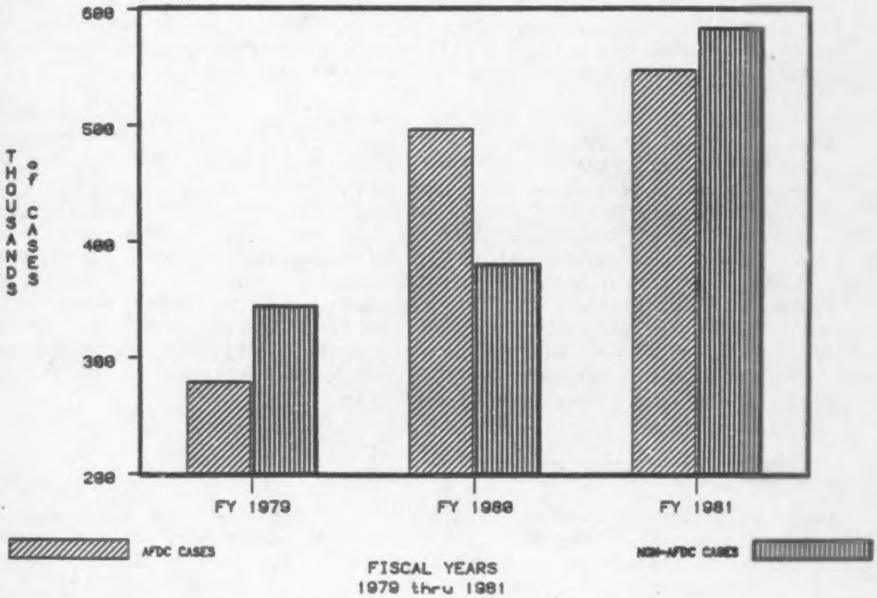
## Increase In Cases Paying

The combined factors of locating the absent parent and establishing an obligation to pay has lead to a significant increase in the number of cases paying each month. Table IX illustrates this trend for both AFDC and non-AFDC cases over a three year period.

This chart points out the number of AFDC and non-AFDC cases paying and should be compared with amounts of money collected as indicated in Tables II and IV.

TABLE IX


AVERAGE NUMBER OF CASES PAYING EACH MONTH

## RESTRUCTURING

In 1982, operating under the premise that the program could be made more effective, "financial restructuring" was sought by OCSE within the Reagan Administration. There was, however, a considerable difference of opinion with regard to "Restructuring" between OCSE and the practitioners involved in the work. OCSE believed that "Restructuring" provided an incentive requirement that would force states to improve their child support programs. The practitioners in this field were convinced that "Restructuring" had major operational deficiencies that would hurt the program and set it back to pre-1975 levels. Although the dramatic restructuring sought by OCSE was not implemented, it is mentioned here since a modified version is currently before Congress.

Federal funding for the Child Support Program should be provided to ensure services for all needy children. The costs of establishing paternity cases should be recognized for their immediate nature as compared to their long range benefits. The AFDC cost avoidance aspect and other services provided in doing non-AFDC work as well as the transient or interstate nature of the absent parent should be considered as major factors in operating the child support network.

Instead of restructuring, the federal funding participation was reduced from 75% to 70% effective October 1, 1982. Effective October 1, 1983, "incentive payments" will be reduced from 15% to 12%. The concern of practitioners in the field is that these reductions will cause program atrophy. The program may dwindle because state and county budgets are, in many instances, not able to carry the load. This reduction in the federal portion conveys a message to all absent parents that non-payment of debts, like child support, is acceptable. Rather than crippling the program by changing the financial structure, emphasis should be placed on enhancing program efficiency through improved program direction. Better laws for the rights of the child, stronger recognition of exisiting laws by the judicial branch, and improved enforcement will bring the savings needed to continue a very effective program.

## THE DILEMMA OF NON-AFDC PROGRAM DIRECTION

A major problem facing all states at this time is how vigorously to pursue the non-AFDC program. The regulations which provide for federal financial participation require the states to provide child support service to both the AFDC and non-AFDC families. However, emphasis is on AFDC collection. Caseload comparisons indicate that the states vary considerably in their approach to working both caseloads. Some states concentrate their main effort in the AFDC area, while others focus on the non-AFDC caseload. Reasons for this vary widely; some states react to state statutes which provide their guidance, while others operate from administrative direction. The paradox each state must face is whether to follow the letter of the law or the direction from the Office of Child Support Enforcement.

The wide variance in the state programs is illustrated by the fact that in one state only 0.9 percentage of their cases are non-AFDC. At the opposite extreme, another state has 81.3 percentage of its cases in the non-AFDC category. The dilemma is highlighted by the fact that both states are apparently meeting federal compliance requirements.

It appears that the reason AFDC has been emphasized over the non-AFDC work has been the difficulty in measuring the cost avoiding aspects of the non-AFDC program. It is noteworthy that a federal contractor, Maximus Corporation, in their first year study of the Child Support Program, concluded that approximately $323 million a year in costs of AFDC assistance were avoided through the states' pursuit of non-AFDC collections. Conversely, in their second year study as published in February 1982, they denied the existence of this cost avoiding aspect and indicated that any savings obtained were essentially lost through increased participation by marginal income households in food stamps and medicaid benefits. Based on the contradictory nature of their reports from year-to-year, it must be concluded that their data at this point is certainly inconclusive.

Currently, OCSE is preparing a contract to determine the cost avoiding aspects of the non-AFDC program. Work on this contract is scheduled to start during the summer of 1983.

One of the primary groups affected by the non-AFDC program are former AFDC recipients who are working in marginal income jobs. Obviously, if child support can be collected for these individuals, then very frequently even minimum wage jobs will preclude their need for assistance. Therefore, the need for strong non-AFDC collection efforts has never been greater or more beneficial.

While both programs are funded at the 70% FFP rate, many states are unsure as to how vigorously to pursue the non-AFDC effort given the current federal philosophy of emphasizing AFDC. Practitioners believe that some direction should be initiated by the U.S. Congress in this area.

Several options are available:

- Increase federal funding for expansion of non-AFDC and interstate services. Required with this is a clear statement that this is the direction to be pursued and that non-AFDC services are important and necessary.

- Continue federal funding at the current level for non-AFDC and interstate services with optional state fees for recovery of costs. Required with this is a clear statement that this is the direction to be pursued and that non-AFDC services are important and necessary.

- Limit program participation to some prescribed level of income. Required with this is a clear statement that service is limited to low income individuals.

- Mandate recovery of costs by some uniform deduction from collections. Required with this is a clear statement that the custodial parent is to bear part of the costs in operating the program.

- Separate federal funding for the AFDC program from the non-AFDC and interstate portion of the program. Each segment should stand alone.

## Problems Within the Present System

The present child support enforcement system lacks reliability and is very slow to react to children's needs. It takes months after a family has separated to procure a child support order and in over 50% of the cases the court order produces little or no results for the child. In comparison, when someone applies for AFDC, rules and regulations ensure that within a 45-day processing period, the eligible applicant will receive money. The AFDC grant is reliable; it comes in monthly and generally the amount is consistent. Thus, the child's subsistence is assured. On the other hand, the custodial parent will often find that the child support order and the enforcement efforts may not produce a payment in time to do any good. Private legal representation is available but most custodial parents find it difficult to meet their basic needs, much less afford legal services.

At first both the child support and AFDC systems appear complicated and intimidating. However, the AFDC system is easier to learn while allowing the client to function independently. This system also provides food stamps and medical care. On the other hand, a lay person has difficulty functioning within the child support system and often has to depend upon legal representation with no guarantee of payment where their children are concerned. It is hard for the custodial parent to understand the delays involved in enforcement and due process for the absent parent. Thus, the child's immediate needs often supercede allowing the child support system a chance to work.

The Child Support Program does offer some relief from these complications for the custodial parent. All the deficiencies and delays are still there but the program does assist the custodial parent with the enforcement process. The practitioners recognize that a child support system that speaks to these problems must be developed so the AFDC Program does not appear to be so attractive.

## Strengths and Accomplishments Within the Present System

More children than ever before receive child support and a larger number of paternity establishments are occurring. Simply stated, the program has created substantial results. States are recognizing the positive influences and are trying to enhance their programs by passing more effective legislation. Wage assignments, chemical analysis to establish paternity, enforcement of support orders through administrative processes and intercepting state/federal tax refunds are improving the efficiency of the system as a whole. Steps have been taken in the area of paternity to reduce blood testing costs and legal fees. Performance measures are being initiated to focus on collection goals.

## POLICY DECISIONS

Considerable progress has been made in the seven year history of the program. Still, challenges remain and basic questions need to be addressed.

- Should the Child Support Program be viewed as a service or revenue generation oriented program?
- Should child support, coupled with an employment readiness and placement program, become the safety net for custodial parents and children who experience financial deprivation when the absent parent leaves the home, or should they depend on AFDC?
- Should a complete system reform occur?

For purposes of discussion, when giving consideration to any type of system reform, it is important to recognize two factors. State administration, resources and environmental factors will vary to such extremes that development will vary within each state. At this point in time, the Title IV-D Child Support Enforcement Program does not represent all children. When reviewing the system as a whole, the variances in each state should be recognized and all children must be considered.

## RECOMMENDATIONS

- A congressional oversight committee should be established to study the ongoing needs of children deprived of child support.
- Initiation of congressional hearings to provide an opportunity for an analysis of the nation's child support network and recommendation for program enhancement.
- The system must obtain initial support payments for the child in less than 45 days.
- National guidelines should be established to determine the child's support needs and allowance.
- A stronger interstate system needs to be developed.
- Legislation must be passed requiring states to have mandatory wage assignments for child support payments.
- Legislation must be passed requiring states to provide for an administrative or quasi-judicial system.
- Legislation must be passed requiring states to provide for offset of state income tax refunds.
- There must be a move from a passive to an active system.
- The emphasis needs to be on collections.
- All employers must be required to provide locate and employment information.

SUMMARY

In the past, federal, state and local governments have not placed enough emphasis on child support enforcement programs. It cannot be overlooked that this lack of emphasis was attributable to the fact that recoupment programs were not compatible with the existing social philosophy. As those times have changed, it may be helpful to refer back to a quote that is well over 100 years old and is still true today.

> "If we first knew where we are and whither we are attending,
> we would better know what to do and how to do it."
> -Abraham Lincoln

It should be the policy of this Administration and Congress that the federal government be actively involved in working with the states to develop more effective and efficient programs. With increased national emphasis, the Child Support Program will get the additional support and recognition so greatly needed at the state and local levels.

Over 13 million children need a system they can depend on. The vast nature of the problem requires attention at the national level. Absent parents cannot be allowed to ignore the most basic obligation -- that of supporting and caring for their children.

Senator DURENBERGER. I was assuming the statistics are all accurate, because if you look behind you, see those empty chairs back there? Those were all occupied by statisticians from the Department of Health and Human Services, I assume, but they seemed to have some difficulty in coming up with accurate responses.

Mr. COPELAND. Yes, sir, they are accurate; but they don't present the appropriate picture. For example, in the State of Alaska we collected $8.5 million last year and spent $2.5 million to do that. However, the figures that they presented would include only the $1 million of AFDC collections that the State of Alaska retained within the State. We sent another $850,000 in AFDC money outside of the State, and then also collected $6.8 million in non-AFDC work.

Now, the figures that they were presenting to you would have indicated Alaska collected $1 million and spent $2.5 million to do that, and the presentation would be made that obviously, then, the State of Alaska has an ineffective program.

Our point is that, no, the law calls for us to do both non-AFDC work and AFDC work on an interstate basis. Paternity establishment is also a requirement. So when you limit it down and just look at their narrow concept, the definition may be correct but their assumptions are totally inappropriate.

Senator DURENBERGER. Thank you very much.

Mr. Abbott?

## STATEMENT OF JOHN P. ABBOTT, UTAH STATE CHILD SUPPORT DIRECTOR, SALT LAKE CITY, UTAH, AND CHAIRMAN, SUBCOMMITTEE ON CHILD SUPPORT, NATIONAL COUNCIL OF PUBLIC WELFARE ADMINISTRATORS, WASHINGTON, D.C.

Mr. ABBOTT. Mr. Chairman, it is an honor to appear before this committee today.

I am John Abbott, director of the office of recovery services for the State of Utah. The views I am expressing here today are also endorsed by the National Council of Public Welfare Administrators of the American Public Welfare Association.

Additionally, I am here to express the views of the State of Utah regarding the administration's proposal. As you may know, Governor Mathison is currently the chairman of the National Governors Association.

I would like to emphasize to the committee that the administration's proposal for child support enforcement must be viewed in two parts.

First of all, the proposal mandates three State laws to enhance child support collections. Now we believe that these laws should be supported by Congress rather than mandated so that individual States can decide which of the procedures would be most cost-effective for them. The support laws are the kind of help the program may need in many States in order to change the odds of parents meeting their support obligations.

As Senator Long so eloquently indicated, there are many instances where insufficient mechanisms exist to bring about payment if the absent parent decides he doesn't want to pay.

The other issue is performance funding. Now, this is the administration's new name for the proposal that was carried last year known as restructuring. Regardless of the name change, however, the concept remains essentially the same. The funding proposal requires States to fund both aspects of the program from AFDC collections. The Federal Government would basically participate in any profit or loss which may incur.

To help stimulate performance, the funding proposal also provides for some bonuses.

Our criticism of the proposal is twofold. First, it only gives a small amount of credit for non-AFDC work. Although this is a step in the right direction to give that program some credit, an additional effort needs to be made to recognize the cost-avoiding aspects of the non-AFDC program.

The program that they are proposing is also void in several other areas. As originally established, the title IV-D act requested the States to address four specific areas: One, AFDC collections; two, non-AFDC collections; three, paternity establishment; and, four, interstate coordination.

Performance funding ignores the high cost and the mandatory nature of paternity establishment. The interstate coordination effort is also totally ignored, and only a token effort has been given for the non-AFDC collections. This leaves us with only one area that the proposal addresses—that being AFDC collections.

I would like to briefly address these issues from Utah's perspective, which would mirror to some extent the experiences in other States. I would like to point out, however, that Utah is one of the more effective and efficient States and has continually led the Nation for the past 5 years in the percentage of AFDC it has collected.

You may well wonder why a State with an effective AFDC child support program would object to a funding scheme that purports to award just such an activity. In my opinion, however, this entire proposal is merely a wolf dressed in lamb's clothing. Allow me to explain why.

In terms of non-AFDC, we will lose approximately $210,000 in Federal revenues. Now, this is true even though our non-AFDC program is geared to address those individuals who are below the poverty line. The question needs to be answered to: Why is the administration doing this? And I believe that the answer is quite obvious, that they wish to deemphasize dramatically the non-AFDC work.

Now, an equally significant oversight is the total lack of any consideration being given for the interstate aspect of the program. The net result will eventually be the elimination of child support enforcement work for other States. The impact of this particular part of the proposal is overwhelming, particularly in the Sunbelt States; but even in Utah where we do enjoy a fairly stable population, 24.6 percent of our total collections come from other States. That equates to a dollar loss to Utah and the Federal Government of $3.4 million.

In conclusion, I would like to indicate that the other major aspect of the program that Senator Long has alluded to, paternity establishment, is a high upfront cost but a long-term benefit to both the family and the Government.

In Utah we are spending 18 percent of our budget on paternity establishment, or in the neighborhood of $1,000 per case. Now, that cost is nowhere considered or rewarded in the performance-funding proposal.

I would like to indicate in closing that we have worked with the Federal Government to mutually beneficial conclusions recently in our revamping of the audit criteria. I think that shows that we are willing, that we are in a posture of readiness to accommodate the administration and Congress in any effort to benefit the program. However, the unilateral proposal that has been developed by the administration we believe should be rejected by this Finance Committee.

I thank you for allowing me to participate.

Senator DURENBERGER. Thank you, Mr. Abbott.

Ms. Hummel?

[The prepared statement of John P. Abbott follows:]

### TESTIMONY OF THE NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS AND NATIONAL COUNCIL OF STATE CHILD SUPPORT ENFORCEMENT ADMINISTRATORS, PRESENTED BY JOHN P. ABBOTT

Mr. Chairman, it is an honor to appear before this Committee today. I am John Abbott, Director of the Office of Recovery Services for the State of Utah. The views that I am expressing are endorsed by the National Council of Public Welfare Administrators of the American Public Welfare Association. Additionally, I am here to express the views of the State of Utah in regards to the Administration's proposals. As you may know, Governor Matheson is the current Chairman of the National Governors' Association.

I would like to emphasize to the Committee that the Administration's proposal for child support enforcement for 1984 must be viewed in two parts:

(1) The proposal mandates three state laws to enhance child support collections. We believe these laws should be supported by Congress rather than mandated, so that individual states can decide which of the procedures would be most cost effective for them. The proposed laws are the kind of help the program may need in many states in order to change the odds of absent parents meeting their support obligations. In many instances, there are insufficient mechanisms in place to bring about payment if absent parents choose not to pay.

(2) Performance Funding, the other issue. This is the Administration's proposal of last year carried under a new name. Regardless of the name change, the concept remains the same. The funding proposal requires states to fund both aspects of the program (ADC and Non-ADC elements) from AFDC collections. The federal government would basically participate in any profit or loss which may occur. To help stimulate performance, the funding proposal also provides for bonuses.

Our criticism of the proposal is two-fold. First, the proposal gives only a small amount of credit for Non-AFDC performance. Although this is a step in the right direction, additional effort needs to be made to give greater recognition to the Non-AFDC portion of the program. Second, the proposal is also void in two other areas: paternity establishment and interstate collections.

We want to reemphasize that the program was originally created in 1975 with four elements in mind: (1) AFDC collections, (2) Non-AFDC collections, (3) Paternity establishment, and (4) Interstate coordination.

Performance funding ignores the high cost and mandatory nature of paternity establishment. The interstate coordination effort is totally ignored and only a token effort has been given to Non-AFDC collections which leaves us with only one area where the proposal addresses the program's original intent . . . AFDC collections.

I would like to briefly address these issues from Utah's perspective, which would mirror to some extent the situations in other states. I would point out, however, that Utah is one of the more effective and efficient states and has continually led the nation for the past 5 years in the percentage of AFDC money recovered through child support collections. You may well wonder why a state with an effective AFDC support program would object to a funding scheme which purports to award just such activity. The reason is the funding proposal is a wolf dressed in lamb's clothing. In terms of our Non-AFDC program, it is rather small with only 1,500 cases. Collections from these cases will amount to $1.5 million this year at a cost of $300,000 state and federal dollars. The federal share of expenditures is now $210,000. Under the performance funding concept, federal contributions would drop to only $40,000 or a loss of $170,000. This is true even though Utah targets our Non-AFDC services to those individuals who would probably be on public assistance were it not for the child support collection. This effort, as you may expect, avoids AFDC expenditures that would otherwise be made at a significant cost to both the state and federal government. The question that needs answering is: Why is the Administration doing this? Quite simply, this turnabout in funding would cause states to dramatically scale down their Non-AFDC programs. This is apparently being done without regard for the public concerns which led to the development of the Economic Equity Act of 1983. Any equally significant oversight is the total lack of any consideration being given in the funding proposal for interstate work. The net result will eventually be the elimination of child support enforcement work for other states. The impact of this oversight is overwhelming in the sunbelt states, but even in Utah, which enjoys a fairly stable population, 24.6 percent of our total collections come from other states. That equates to a dollar loss to Utah and the federal government of $3.4 million in this small state alone. Imagine the impact to states like New York and California.

In closing, let me emphatically state that the performance based funding proposal being advocated by the Administration will truly devastate the child support enforcement program and the progress that has been made in the past seven years. I would like to stress, however, that those I represent here today stand ready to assist both the Administration and Congress in developing the means to enhance performance within the child support enforcement program.

Thank you for allowing me to express our views.

## STATEMENT OF BETTY HUMMEL, ADMINISTRATOR, KANSAS CHILD SUPPORT ENFORCEMENT PROGRAM, TOPEKA, KANS., AND LEGISLATIVE CHAIRMAN, NATIONAL RECIPROCAL FAMILY SUPPORT ENFORCEMENT ASSOCIATION, DES MOINES, IOWA

Ms. **Hummel**. Mr. Chairman and members of the Senate Finance Committee, I am Betty Hummel, the administrator of the Kansas child support enforcement program, and legislative chairman of the National Reciprocal Family Support Enforcement Association.

I am here today speaking on their behalf.

The administration's 1984 proposal for child support enforcement impacts two program areas: Program funding and legislation.

The National Reciprocal Family Support Enforcement Association supports the adminstration's legislative proposals regarding mandatory wage assignment, State tax intercept, and the administrative and/or quasi-judicial support establishment and enforcement process.

Mandatory wage assignment and State tax intercept are two processes that will greatly intensify collection efforts.

Senator LONG. Ms. Hummel, would you hold it just a minute? I am trying to find your statement here so that I can read along and follow what you are saying.

Senator DURENBERGER. Are you reading a summary from the larger statement?

Ms. HUMMEL. Yes, sir. I have digressed from that because of the time element.

Senator LONG. Are you reading the summary rather than the statement?

Ms. HUMMEL. No, sir, I am going through the statement, but I have deleted much because of the time constraints.

Senator LONG. Page four?

Senator DURENBERGER. Right.

Senator LONG. Thank you.

Senator DURENBERGER. Please continue.

Ms. HUMMEL. Mandatory wage assignments and State income tax intercept are processes that will greatly intensify collections.

The administrative and/or quasi-judicial system allows the State to adjudicate child support obligations, thus reducing the waiting period that is experienced in court cases. This will result in child support moneys being sent directly to the family far more quickly, once again placing the support burden where it should be with the responsible parent and reducing welfare dependency.

Couple the administrative process with a mandatory wage assignment, and the entire process will be streamlined reducing court backlogs, requiring less legal activities, while still assuring the constitutional guarantee of due process. The administrative process can be individually designed to meet the hybrid needs of the State, thus giving each State flexibility to develop a system that complements their existing laws and public policy.

We are, however, opposed to the performance funding proposal that the administration is recommending. We forecast that, if implemented, the performance funding will not enhance the program; it will do the reverse—set back the program.

The fact is that the State of Kansas, or States like Kansas, will have immediate problems, not only because the long-term funding is a revolutionizing method of approaching State funding but it also has long-term detrimental administrative effects.

We are concerned about the negative impact on local jurisdictions such as local prosecutors, friends of the court, and court trustees. Counties will have difficulty in trying to adequately project collections and expenditures; determining potential bonus awards, since the State will not have control over the calculations; planning future program enhancements, since the funding mechanism is so unreliable; and determining program priorities, since the Federal focus could be at odds with local constituent needs.

The States are concerned about the administrative flaws also in the formula. The States presently have to face the dilemma that children have been placed into two categories for the sake of this particular program—AFDC and non-AFDC—even though their needs remain the same they do not receive their child support.

Performance funding further polarizes the issue between AFDC and non-AFDC. If States are to be judged on completeness and adequacy of coverage in both programs yet funded under different criteria, we will not succeed.

We are critical of the funding proposal because it places total management and financial burden while imposing extensive audit criteria with threats of penalty.

Phase two of the performance funding formula sets forth bonus awards. These awards are supposed to generate a spirit of competitiveness among States, thus motivating States to control expenditures, increase ADC collections, and give us some modest recognition of our non-ADC. We suggest that this end result will have a negative impact:

We will spend more time looking at funding and implementation problems; bonus awards will be difficult to calculate and will be validated many months later; we will be hesitant in trying to look at long-term enhancements because of the tremendous unreliability of the formula; the bonus awards will also not help poor performing States to improve, and eventually high performance States will peak out, and the reward for strong management will be reduced bonus awards.

In closing, the administration is presently developing regulations to change the program's audit criteria, which will place greater emphasis on performance measures than program compliance. This change will accomplish the same end result as the formula, but it will take longer to implement; thus, the administration has a secondary means of actually resolving this issue.

We appreciate the committee looking at the child support program, and we are going to continue to work to make sure that the beneficiaries of this program are the children of this country and the local taxpayers. We ask that you relieve the program of this proposed funding formula.

Thank you.

Senator **Durenberger**. Thank you. It sounds great to me.

[The prepared statement of Betty A. Hummel follows:]

## Statement of Betty A. Hummel, Kansas Child Support Enforcement Program and National Reciprocal and Family Support Enforcement Association

### SUMMARY

Mr. Chairman and members of the Senate Finance Committee, the state of Kansas and the National Reciprocal and Family Support Enforcement Association oppose performance funding and endorse maintaining the present operational funding system of 70 percent federal matching funds and 15/12 percent federal incentive.

We oppose performance funding because it:

1. Lacks an incentive to remove families from public assistance by increasing the child support collection;

2. Reduces the overall benefit to the taxpayer without meaningfully enhancing the overall program purpose;

3. Creates many administrative implementation problems that has not been satisfactorily addressed;

4. Indirectly condones deemphasizing the non-ADC program and paternity establishment;

5. Destroys interstate cooperation thus creating escape havens; and

6. Significantly reduces program momentum since cutbacks will allow for greater shirking of parental and financial responsibilities.

The present funding system has:

1. Provided the local taxpayer with a consistent profit over the costs;

2. Established a built-in cost control with local jurisdictions and the state since 30 percent local and state funds are used to match the federal funding;

3. Already demonstrated significant long-term cost avoidance through the establishment of paternity and the enforcement of nonwelfare cases; and

4. Created a basis for the establishment for more sophisticated enforcement laws e.g., federal and state tax intercept programs which show promise in profitting not only the local taxpayer but also the federal government.

The Administration is presently developing regulations to change the program's audit criteria which will place greater emphasis on performance measures than program compliance. This change will accomplish the same end result as performance funding but will take more time to implement. Thus, the Administration has a secondary means of resolving the issue through their audit system.

We believe that Congress needs to act now to relieve the program of this proposed funding formula threat. Tampering with the current program by imposing the new funding formula would be undermining the development of a progam which already runs concurrent to the goals of both Congress and the Administration. . . to reduce the federal budget. We are prepared to work with you so that the beneficiaries of this program will remain the children of this country and the local taxpayer.

## STATEMENT

Mr. Chairman and members of the Senate Finance Committee, the State of Kansas, Child Support Enforcement Program is grateful for the opportunity to present our concerns and recommendations regarding the proposed 1984 fiscal year budget reductions that affect the Child Support Enforcement Program. I am Betty Hummel, Administrator for the Kansas Child Support Enforcement Program and legislative chairman for the National Reciprocal Family Support Enforcement Association. I am here to also express their endorsement of this position.

The Administration's 1984 proposal for Child Support Enforcement impacts two areas: program funding and legislation. The National Reciprocal Family Support Enforcement Association supports the administration's legislative proposals regarding mandatory wage assignment, state tax intercept and the administrative and/or quasi-judicial support establishment and enforcement process. This part of the administration's proposal is positive, enhancing the state's enforcement remedies. Unlike the performance funding proposal, these pieces of legislation will build rather than erode the program's enforcement foundation which has been developed over the last seven years.

Mandatory wage assignments and state income tax intercept are two processes that will greatly intensify collection efforts. Furthermore, both efforts ensure that the support of children is met by those responsible for their children . . . and not the taxpayer. Research done by Dr. Lenore J. Weitzman, Stanford University, leads her to conclude that the lack of compliance with support with support orders lies within an absence or a failure to use effective enforcement techniques.[1]

This is even more critical when Dr. Weitzman predicts that 40 percent of the American marriages contracted in the 1980's will end in divorce and that by 1990's only 56 percent of the children in the United States will spend their entire childhood living witn both parents.[2] I mention this because this study emphasizes the long-term nature of this problem. What we do here today will impact on the reality of how these children, victims of even higher divorce rates, will survive if child support enforcement approaches are weakened.

The administrative and/or quasi-judicial system allows the state to adjudicate child support obligations thus reducing the waiting period that is experienced in court cases. This will result in child support monies being sent directly to the family far more quickly. Secondly, this places the case in an enforcement and collection status within a much shorter period of time, once again, placing the support burden where it should be . . . with the responsible parent and reducing welfare dependency.

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[1] Weitzman, Lenore J., "The Economic Consequences of Divorce: Social and Economic Consequences of Property, Alimony, and Child Support Awards," 28 U.C.L.A.L.R. 1181 (1981).

[2] Weitzman, 1981.

Couple the administrative process with a mandatory wage assignment and the entire process has been streamlined reducing court backlogs, requiring less legal activities while still ensuring constitutional guarantees such as due process. The administrative process can be individually designed to meet the hybrid needs of the state thus giving each state flexibility to develop a system that compliments existing laws and public policy.

*Administration's Funding Proposal*

We are opposed to the performance funding proposal that the Administration is recommending. It is projected to produce a savings of $298 million with a breakdown of:

[In millions of dollars]

| Projected program savings | Performance— | |
|---|---|---|
| | Funding | Mandated laws |
| Fiscal year: | | |
| 1984 ($66) | $10 | $56 |
| 1985 ($107) | 51 | 56 |
| 1986 ($125) | 69 | 56 |

Performance funding is conceptualized by the Administration as a formula which will increase the state's effectiveness and efficiency. This standard of measurement sets forth the expectation that the Federal Government should have full recovery of their dollar investment. This forces me to ask . . . is it general practice for the Federal Government to invest dollars in programs with expectations of total dollar recovery?

Our conclusions are that the beneficiaries of the formula will be the administration. The losers in the proposal are the children of Kansas and other states, who will receive several millions of dollars less in support monies, and the local taxpayer because the program will be weakened. Under present funding, the local taxpayer has consistently been a beneficiary both at the county and state level in addition to the millions of dollars that have been collected.

The states continue to strive for program improvement. We concur that the states have a responsibility to the taxpayer to be not only effective but efficient in operating such a program. We pledge to administer quality child support programs in the best interest of this nation's children.

The Administration is presently developing regulations to change the program's audit criteria which will place greater emphasis on performance measures than program compliance. This change will accomplish the same end result as performance funding but will take more time to implement. Thus, the Administration has a secondary means of resolving the issue through their audit system.

We forecast that if implemented, performance funding will not enhance the program, it will do the reverse . . . set back the program. No matter how outstanding a particular program might be, with all the changes coming forth, states and their local political subdivisions will have to adjust present program emphasis due to the reduction in funding. The bottom line is funding cutbacks will be undertaken and the end result will be a reduction in collections. Coupled with this will be a decrease in effectiveness because monitoring and follow-up activities will diminish, leaving America's children and local taxpayers victims of the system.

*Facts About the Funding Formula*

The following data provides you with a brief overview of how several states will be affected by program funding:

| States | Restructuring | Current |
|---|---|---|
| Florida | $3,771,800 | $5,082,100 |
| Idaho | 1,254,400 | 1,188,800 |
| Kansas | 2,886,091 | 3,424,900 |
| Louisiana | 741,401 | 1,598,916 |
| Minnesota | 7,810,000 | 10,460,000 |
| Michigan | 55,300,000 | 54,980,000 |
| New York | 16,000,000 | 26,900,000 |
| Oregon | 4,173,076 | 4,434,904 |
| Pennsylvania | 8,700,000 | 22,800,000 |
| Texas | 9,690,997 | 12,689,593 |

Conclusions drawn from the data above might lead one to ask, why are states that experience a gain and/or marginal change in their operational system under performance funding still opposed to the formula. The fact is, states like Kansas will have immediate problems not only because the funding formula revoluntionizes state funding methodology, it also has long-term detrimental administrative affects.

1. Negative Impact on Local Jurisdictions: The administration has failed to recognize that the funding formula will have the most negative impact on local county prosecutors, friends of the court and/or court trustees. Counties have little, if any, flexibility in their budgeting process. Since the entire basis for the formula relies on one's projecting abilities, there is reason for concern. Counties will have difficulties in:

(a) Trying to adequately project collections and expenditures—many counties do not have comptrollers or budget administrators which will handicap ongoing implementation;

(b) Determining potential bonus awards since the state will not have control over this;

(c) Planning future program enhancements since the funding mechanism is so unreilable; and

(d) Determining program priorities since the federal focus could be opposite what local constituents need.

2. Negative Impact on the States: The states are concerned about the administrative flaws in the formula. We believe that Congress needs to carefully review and act now to relieve the program of this proposed funding formula threat. Our primary concerns are:

(a) ADC vs. Non-ADC Program: The states presently have to face the dilemma that children have been placed into two categories for the sake of this program; ADC and non-ADC, even though their needs are the same, . . . they do not receive their child support. These children are vulnerable and less fortunate. Hopefully, we, as a nation, are not less committed to these children. Preformance funding further polarizes the issue between ADC and non-ADC. If states are to be judged on completeness and adequacy of coverage in both programs yet funded under different criteria, we will not succeed.

The program now has five operational components: (1) Non-ADC collections; (2) ADC reimbursement; (3) Paternity Establishment; (4) Interstate Activities; and (5) Third Party Medical Information Gathering.

Four of these components do not directly impact the program's revenue potential. We are critical of the performance funding formula because it places total management and financial burden on the state for these five components while imposing extensive audit criteria with threats of penalty. Is it logical to expect the states to rejoice over losing local funding dollars, assuming the total financial and operational aspect of the program, meeting federal auditing standards under pain of penalty and turning a profit for this outside shareholder which provides little or no service?

It can be argued that the formula does discount the non-ADC component by a cost-avoidance computation; however, the computation provides little tangible results and is merely and effort to camouflage the administration's failure to adequately address our concerns with the formula, particularly the non-ADC element.

b. Lack of Incentives: Phase two of the performance funding formula sets forth bonus awards. These awards are suppose to generate a spirit of competiveness among states thus motivating states to control expenditures, increase ADC collections, and receive some recognition for their non-ADC collections. We are suggesting that this end result will have a negative impact on the overall program because:

(a) Too much time will be spent on funding and implementation problems rather than planning and developing more efficient management techniques;

(2) Bonus awards will take too much time to claculate and validate;

(3) The fomula is two tiered with applied methodology being based on four quarters which are contrary to most states and local jurisdictions' fiscal years. Bonus awards will be reconciliated once a year after the four quarters are determined rather than monthly which the present system allows. Thus prosecutors and states will have to become experts in collections and expenditure forecasting and will be expected to accurately predict unemploymnet rates, inflationary factors, and other economic conditions which are standards presently unachievable by well-known economists and the administration. Payment of the bonus award will come so long after the fact that it will lose its impact.

(4) States will be hesitant to add long-term enhancements such as staff and computer development because of the tremendous financial commitment that would be necessary and the funding formula is financially unreliable.

(5) The formula rewards states which contain costs and increase ADC collections which means paternity establishment, non-ADC and interstate activities lack adequate recognition in the formula. To reduce costs, states will have no choice but to diminish services in these three areas. This means that absent parents can avoid parental and financial responsibilities by simply crossing state lines and refusing paternity acknowledgement. The true incentive will be to keep families on ADC because once they are no longer eligible for asistance, the collection does not count so states will learn how to collect just enough child support so families will not become ineligible. This is probably the most discouraging fact because this is totally at cross purposes for what we are trying to accomplish; and

(6) The bonus awards will not help poor performing states to improve and eventually, high performing states will peak out and their reward for strong consistent management will be reduced bonus awards.

*Recommendations*

We recommend that Congress recognize the momentum that is behind this program and strengthen it. Instead of focusing on a funding formula that will weaken the program, reverting back to a permissiveness which allows parents to shirk their responsibility, address remedies that will stiffen the penalty such as:

1. Enhancing our enforcement remedies through mandatory wage assignment, administrative process, and state tax intercept laws;
2. Reemphasizing a strong commitment to the non-ADC portion of the program;
3. Developing stronger more uniform interstate family support laws. Interstate cases are inherently difficult even with the Unform Reciprocal Support Act; and
4. Strengthening the domestic court system by encouraging a family court system that strongly addresses domestic matters on the front end where the problem begins. The current "pay and chase" method has proven historically to be cumbersome and inefficient.

In summary, we believe that Congress needs to act now to relieve the program of this proposed funding threat. The momentum of this program should not be stymied by further bureaucratic entanglement. We feel tampering with the current program by imposing the performance formula would be undermining the development of a program which already runs concurrent to the goals of both Congress and the Administration . . . to reduce the federal budget. Instead, Congress should provide positive reinforcement by publicly endorsing the program's efforts and enhancing through legislation the enforcement remedies.

Thank you for the opportunity to testify. We are pleased that the Committee is carefully reviewing the merits of the Child Support Enforcement Program. We are prepared to work with you so that the beneficiaries of this program will remain the children of this county and the local taxpayer.

Senator **Durenberger**. Yes?

Mr. **Abbott**. Mr. Chairman, if I may, a recent Supreme Court decision in regards to paternity was just released on June 6. If I may, I would like to submit this for inclusion in the record.

Senator **Durenberger**. Without objection it may be made a part of the record.

[The U.S. Supreme Court decision follows:]

(Slip Opinion)

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States* v. *Detroit Lumber Co.*, 200 U. S. 321, 337.

# SUPREME COURT OF THE UNITED STATES

## Syllabus

## PICKETT ET AL. *v.* BROWN ET AL.

APPEAL FROM THE SUPREME COURT OF TENNESSEE

No. 82–5576. Argued April 27, 1983—Decided June 6, 1983

Under Tennessee law the father of an illegitimate child is responsible for the child's support. Enforcement of this obligation depends on the establishment of paternity. A Tennessee statute provides that a paternity and support action must be filed within two years of the child's birth unless the father has provided support or has acknowledged his paternity in writing, or unless the child is, or is liable to become, a public charge, in which case the State or any person can bring suit at any time prior to the child's 18th birthday. In May 1978, appellant mother of an illegitimate child born in November 1968 brought a paternity and support action in the Tennessee Juvenile Court against appellee Brown, who moved to dismiss the action on the ground that it was barred by the 2-year limitations period. The court held that the limitations period violated, *inter alia*, the Equal Protection Clause of the Fourteenth Amendment, because it imposed a restriction on the support rights of some illegitimate children that was not imposed on the identical rights of legitimate children. The Tennessee Supreme Court reversed and upheld the constitutionality of the 2-year limitations period.

*Held:* The 2-year limitations period in question denies certain illegitimate children the equal protection of the law guaranteed by the Fourteenth Amendment. Pp. 5–16.

(a) Restrictions on support suits by illegitimate children "will survive equal protection scrutiny to the extent that they are substantially related to a legitimate state interest." *Mills* v. *Habluetzel*, 456 U. S. 91, 99. The period for obtaining paternal support has to be long enough to provide a reasonable opportunity for those with an interest in illegitimate children to bring suit on their behalf; and any time limit on that opportunity has to be substantially related to the State's interest in preventing the litigation of stale or fraudulent claims. *Id.*, at 99–100. Pp. 5–10.

(b) Here, the 2-year limitations period does not provide an illegitimate child who is not covered by one of the exceptions in the statute with an adequate opportunity to obtain support. The mother's financial difficulties caused by the child's birth, the loss of income attributable to the need to care for the child, continuing affection for the child's father, a desire to avoid family and community disapproval, and emotional strain and confusion that often attends the birth of an illegitimate child, all may inhibit a mother from filing a paternity suit within two years after the child's birth. Pp. 10–12.

(c) Nor is the 2-year limitations period substantially related to the legitimate state interest in preventing the litigation of stale or fraudulent calims. It amounts to a restriction effectively extinguishing the support rights of illegitimate children that cannot be justified by the problems of proof surrounding paternity actions. The State's argument that the different treatment accorded legitimate and illegitimate children is substantially related to the above legitimate state interest is seriously undermined by the exception for illegitimate children who are, or are likely to become, public charges, since claims filed on behalf of these children when they are more than two years old would be just as stale or as vulnerable to fraud as claims filed on behalf of illegitimate children who are not public charges at the same age. Moreover, the fact that Tennessee tolls most actions during a child's minority, when considered in combination with the above factors, leads one to question whether the burden placed on illegitimate children is designed to advance permissible state interests. And the advances in blood testing render more attenuated the relationship between a statute of limitations and the State's interest in preventing the litigation of stale or fraudulent claims. Pp. 12–16.

638 S. W. 2d 369, reversed and remanded.

BRENNAN, J., delivered the opinion for a unanimous Court.

NOTICE: This opinion is subject to formal revision before publication in the preliminary print of the United States Reports. Readers are requested to notify the Reporter of Decisions, Supreme Court of the United States, Washington, D. C. 20543, of any typographical or other formal errors, in order that corrections may be made before the preliminary print goes to press.

# SUPREME COURT OF THE UNITED STATES

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## No. 82-5576

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## JEFFREY LEE PICKETT, ETC. ET AL., APPELLANTS *v.* BRAXTON BROWN ET AL.

APPEAL FROM THE SUPREME COURT OF TENNESSEE, WESTERN DIVISION

[June 6, 1983]

Justice Brennan delivered the opinion of the Court.

This case requires us to decide the constitutionality of a provision of a Tennessee statute[1] that imposes a two-year limitations period on paternity and child support actions brought on behalf of certain illegitimate children.

### I

Under Tennessee law both fathers and mothers are responsible for the support of their minor children. See Tenn. Code Ann. § 34-101 (1977); *Rose Funeral Home, Inc.* v. *Julian*, 176 Tenn. 534, 539, 144 S. W. 2d 755, 757 (1940); *Brooks* v. *Brooks*, 166 Tenn. 255, 257, 61 S. W. 2d 654 (1933). This duty of support is enforceable throughout the child's minority. See *Blackburn* v. *Blackburn*, 526 S.W. 2d 463, 466

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[1] Tennessee Code Ann. § 36-224(2) (1977) reads as follows:

"(2) Proceedings to establish the paternity of the child and to compel the father to furnish support and education for the child may be instituted during the pregnancy of the mother or after the birth of the child, but shall not be brought after the lapse of more than two (2) years from the birth of the child, unless paternity has been acknowledged by the father in writing or by the furnishing of support. Provided, however, that the department of human services or any person shall be empowered to bring a suit in behalf of any child under the age of eighteen (18) who is, or is liable to become a public charge."

(Tenn. 1975); *Whitt* v. *Whitt*, 490 S. W. 2d 159, 160 (Tenn. 1973). See also Tenn. Code Ann. §§36-820, 36-828 (1977). Tennessee law also makes the father of a child born out of wedlock responsible for "the necessary support and education of the child." §36-223. See also *Brown* v. *Thomas*, 221 Tenn. 319, 323, 426 S. W. 2d 496, 498 (1968). Enforcement of this obligation depends on the establishment of paternity. Tennessee Code Ann. §36-224(1) (1977)[2] provides for the filing of a petition which can lead both to the establishment of paternity and to enforcement of the father's duty of support. With a few exceptions, however, the petition must be filed within two years of the child's birth. See §36-224(2); n. 1, *supra*.

In May 1978, Frances Annette Pickett filed an action pursuant to §36-224(1) seeking to establish that Braxton Brown was the father of her son, Jeffrey Lee Pickett, who was born on November 1, 1968. App. 3. Frances Pickett also sought an order from the court requiring Brown to contribute to the support and maintenance of the child. *Ibid.* Brown denied that he was the father of the child. *Id.*, at 13. It is uncontested that he had never acknowledged the child as his own or contributed to the child's support. *Id.*, at 5-6, 13-14; Brief for Appellant 5. Brown moved to dismiss the suit on the ground that it was barred by the two-year limitations period established by § 36–224(2). Frances Pickett responded with a motion challenging the constitutionality of the limitations period. App. 5–7, 13.[3]

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[2] Tennessee Code Ann. §36-224(1) (1977) reads as follows:

"(1) A petition to establish paternity of a child, to change the name of the child if it is desired, and to compel the father to furnish support and education for the child in accordance with this chapter may be filed by the mother, or her personal representative, or, if the child is likely to become a public charge by the state department of human services or by any person. Said petition may be filed in the county where the mother or child resides or is found or in the county where the putative father resides or is found. The fact that the child was born outside this state shall not be a bar to filing a petition against the putative father. After the death of the mother or in case of her disability said petition may be filed by the child acting through a guardian or next friend."

The Juvenile Court held that the two-year limitations period violated the Equal Protection Clause of the Fourteenth Amendment of the Federal Constitution and certain provisions of the Tennessee Constitution. *Id.*, at 14. The court based its conclusion on the fact that the limitations period governing paternity actions imposed a restriction on the support rights of some illegitimate children that was not imposed on the identical rights of legitimate children. *Ibid.* Without articulating any clear standard of review, the court rejected the State's argument that the two-year limitations period was justified by the State's interest in preventing the litigation of "stale or spurious" claims. *Id.*, at 15. In the court's view, this argument was undermined by the exception to the limitations period established for illegitimate children who are, or are likely to become, public charges, for "the possibilities of fraud, perjury, or litigation of stale claims [are] no more inherent in a case brought [for] a child who is not receiving public assistance than [in] a case brought for a child who is a public charge." *Ibid.*[4]

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[3] Frances Pickett challenged the statute on equal protection and due process grounds under both the Federal and State Constitutions. App. 6–7. She also alleged that the statute amounted to cruel and unusual punishment under both the Federal and State Constitutions. *Ibid.* The Juvenile Court did not address this claim. The Tennessee Supreme Court later noted that she did not seriously press it before that court. *Pickett* v. *Brown*, 638 S. W. 2d 369, 371 (Tenn. 1982). She also does not advance it before this Court.

Pickett also sought permission to amend her complaint to bring the paternity suit in the name of her child. App. 6.

After Pickett filed her motion challenging the constitutionality of the statute the State Attorney General was notified and he intervened to defend the statute. See App. 13; 638 S. W. 2d, at 371.

[4] The court also found that the statute discriminated between "children born out of wedlock who are receiving public assistance and such children

On appeal,[5] the Tennessee Supreme Court reversed the judgment of the Juvenile Court and upheld the constitutionality of the two-year limitations period. *Pickett* v. *Brown*, 638 S. W. 2d 369 (Tenn. 1982). In addressing Frances Pickett's equal protection and due process challenges to the statute, the court first reviewed our decision in *Mills* v. *Habluetzel*, 456 U. S. 91 (1982), and several decisions from other state courts. Based on this review, the court stated that the inquiry with respect to both claims was "essentially the same: whether the state's policy as reflected in the statute affords a fair and reasonable opportunity for the mother to decide in a rational way whether or not the child's best interest would be served by her bringing a paternity suit." 638 S. W. 2d, at 376. The court concluded that "[t]he Legislature could rationally determine that two years is long enough for most women to have recovered physically and emotionally, and to be able to assess their and their children's situations logically and realistically." *Id.*, at 379.

The court also found that the two-year statute of limitations was substantially related to the State's valid interest in preventing the litigation of stale or fraudulent claims. *Id.*, at 380. The court justified the longer limitations period for illegitimates who are, or are likely to become, public charges, on the ground that "[t]he state's countervailing interest in doing justice and reducing the number of people on welfare is served by allowing the state a longer time during which to sue." *Ibid.* The court also suggested that "the Tennessee

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whose mothers are not receiving public assistance." App. 15–16. In this regard, the court pointed out that a mother's fulfillment of her obligation to support her child does not relieve the father of his duty of support. *Id.*, at 16.

The court granted Pickett permission to amend her complaint to bring the suit in the name of her child. *Ibid.*

[5] The Juvenile Court "allowed an interlocutory appeal by certifying that the constitutionality of [Tenn. Code Ann.] § 36–224(2) was the sole determinative question of law in the proceedings." 638 S. W. 2d, at 371.

statute is 'carefully tuned' to avoid hardship in predictable groups of cases, since it contains an exception for actions against men who have acknowledged their children in writing or by supporting them, and it has been held that . . . regular or substantial payments are not required in order to constitute 'support.'" *Id.*, at 379. Finally, the court found that the uniqueness of the limitations period in not being tolled during the plaintiff's minority did not "alone requir[e] a holding of unconstitutionality of a two-year period, as opposed to any other period which can end during the plaintiff's minority." *Id.*, at 380.[6]

We noted probable jurisdiction. —— U. S. —— (1982). We reverse.

## II

We have considered on several occasions during the past 15 years the constitutional validity of statutory classifications based on illegitimacy. See, *e. g.*, *Mills* v. *Habluetzel*, *supra*; *United States* v. *Clark*, 445 U. S. 23 (1980); *Lalli* v. *Lalli*, 439 U. S. 259 (1978); *Trimble* v. *Gordon*, 430 U. S. 762 (1977); *Mathews* v. *Lucas*, 427 U. S. 495 (1976); *Jiminez* v. *Weinberger*, 417 U. S. 628 (1974); *New Jersey Welfare Rights Org.* v. *Cahill*, 411 U. S. 619 (1973); *Gomez* v. *Perez*, 409 U. S. 535 (1973); *Weber* v. *Aetna Casualty & Surety Co.*, 406 U. S. 164 (1972); *Glona* v. *American Guarantee Co.*, 391 U. S. 73 (1968); *Levy* v. *Louisiana*, 391 U. S. 68 (1968). In several of these cases, we have held the classifications invalid. See, *e. g.*, *Mills* v. *Habluetzel*, *supra*; *Trimble* v.

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[6] The court also rejected the due process challenge to the statute. 638 S. W. 2d, at 376, 380.

In addition, the court found that the Juvenile Court had committed a harmless error, from which Brown and the State did not appeal, in allowing Pickett "to amend her complaint to add the name of the child, by the mother as next friend, as a plaintiff." *Id.*, at 380. The court stated that § 36-224(1) "does not permit an action to be brought by the child except in case of death or disability of the mother." *Ibid.*

*Gordon, supra*; *Jiminez* v. *Weinberger, supra*; *New Jersey Welfare Rights Org.* v. *Cahill, supra*; *Gomez* v. *Perez, supra*; *Weber* v. *Aetna Casualty & Surety Co., supra*; *Glona* v. *American Guarantee Co., supra*; *Levy* v. *Louisiana, supra.* Our consideration of these cases has been animated by a special concern for discrimination against illegitimate children. As the Court stated in *Weber*:

> "The status of illegitimacy has expressed through the ages society's condemnation of irresponsible liaisons beyond the bonds of marriage. But visiting this condemnation on the head of an infant is illogical and unjust. Moreover, imposing disabilities on the illegitimate child is contrary to the basic concept of our system that legal burdens should bear some relationship to individual responsibility or wrongdoing. Obviously, no child is responsible for his birth and penalizing the illegitimate child is an ineffectual—as well as an unjust—way of deterring the parent. Courts are powerless to prevent the social opprobrium suffered by these hapless children, but the Equal Protection Clause does enable us to strike down discriminatory laws relating to status of birth where—as in this case—the classification is justified by no legitimate state interest, compelling or otherwise." 406 U. S., at 175–176 (footnotes omitted).

In view of the history of treating illegitimate children less favorably than legitimate ones, we have subjected statutory classifications based on illegitimacy to a heightened level of scrutiny. Although we have held that classifications based on illegitimacy are not "suspect," or subject to "our most exacting scrutiny," *Trimble* v. *Gordon*, 430 U. S., at 767; *Mathews* v. *Lucas*, 427 U. S., at 506, the scrutiny applied to them "is not a toothless one. . . ." *Id.*, at 510. In *United States* v. *Clark, supra,* we stated that "a classification based on illegitimacy is unconstitutional unless it bears 'an evident and substantial relation to the particular . . . interests [the] statute is designed to serve.'" 445 U. S., at 27. See also *Lalli* v. *Lalli*, 439 U. S., at 265 (plurality opinion) ("classifications based on illegitimacy . . . are invalid under the Fourteenth Amendment if they are not substantially related to permissible state interests"). We applied a similar standard of review to a classification based on illegitimacy last Term in *Mills* v. *Habluetzel*, 456 U. S. 91 (1982). We stated that restrictions on support suits by illegitimate children "will survive equal protection scrutiny to the extent they are substantially related to a legitimate state interest." *Id.*, at 99.

Our decisions in *Gomez* and *Mills* are particularly relevant to a determination of the validity of the limitations period at issue in this case. In *Gomez* we considered "whether the laws of Texas may constitutionally grant legitimate children a judicially enforceable right to support from their natural fathers and at the same time deny that right to illegitimate children." 409 U. S., at 535. We stated that "a State may not invidiously discriminate against illegitimate children by denying them substantial benefits accorded children generally," *id.*, at 538, and held that "once a State posits a judicially enforceable right on behalf of children to needed support from their natural fathers there is no constitutionally sufficient justification for denying such an essential right to a child simply because its natural father has not married its mother." *Ibid.* The Court acknowledged the "lurking problems with respect to proof of paternity," *id.*, and suggested that they could not "be lightly brushed aside." *Ibid.* But those problems could not be used to form "an impenetrable barrier that works to shield otherwise invidious discrimination." *Ibid.*

In *Mills* we considered the sufficiency of Texas' response to our decision in *Gomez*. In particular, we considered the constitutionality of a one-year statute of limitations governing suits to identify the natural fathers of illegitimate children. 456 U. S., at 92. The equal protection analysis focused on two related requirements: the period for obtaining paternal support has to be long enough to provide a reasonable opportunity for those with an interest in illegitimate children to bring suit on their behalf; and, any time limit on that opportunity has to be substantially related to the State's interest in preventing the litigation of stale or fraudulent claims. *Id.*, at 99–100.

The Texas statute failed to satisfy either requirement. The one-year period for bringing a paternity suit did not provide illegitimate children with an adequate opportunity to obtain paternal support. *Id.*, at 100. The Court cited a variety of factors that make it unreasonable to require that a paternity suit be brought within a year of a child's birth. *Ibid.*[7] In addition, the Court found that the one-year limitations period was not "substantially related to the State's interest in preventing the prosecution of stale or fraudulent claims." *Id.*, at 101. The problems of proof surrounding paternity suits do not "justify a period of limitation which so restricts [support rights] as effectively to extinguish them." *Ibid.* The Court could "conceive of no evidence essential to paternity suits that invariably will be lost in only one year, nor is it evident that the passage of 12 months will appreciably increase the likelihood of fraudulent claims." *Ibid.* (footnote omitted).[8]

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[7] The Court suggested that "[f]inancial difficulties caused by childbirth expenses or a birth-related loss of income, continuing affection for the child's father, a desire to avoid disapproval of family and community, or the emotional strain and confusion that often attend the birth of an illegitimate child all encumber a mother's filing of a paternity suit within 12 months of birth." *Mills* v. *Habluetzel*, 456 U. S. 91, 100 (1982). The Court also pointed out that "[e]ven if the mother seeks public financial assistance and assigns the child's support claim to the State, it is not improbable that 12 months would elapse without the filing of a claim." *Ibid.* In this regard, the Court noted that "[s]everal months could pass before a mother finds the need to seek such assistance, takes steps to obtain it, and is willing to join the State in litigation against the natural father." *Ibid.* (footnote omitted).

[8] The Court found no need to reach a due process challenge to the stat-

In a concurring opinion, JUSTICE O'CONNOR, joined by four other Members of the Court,[9] suggested that longer limitations periods also might be unconstitutional. *Id.*, at 106.[10] JUSTICE O'CONNOR pointed out that the strength of the State's interest in preventing the prosecution of stale or fraudulent claims was "undercut by the countervailing state interest in ensuring that genuine claims for child support are satisfied." *Id.*, at 103. This interest "stems not only from a desire to see that 'justice is done,' but also from a desire to reduce the number of individuals forced to enter the welfare rolls." *Ibid.* (footnote omitted). JUSTICE O'CONNOR also suggested that the State's concern about stale or fraudulent claims "is substantially alleviated by recent scientific developments in blood testing dramatically reducing the possibility that a defendant will be falsely accused of being the illegitimate child's father." *Id.*, at 104, n. 2. Moreover, JUSTICE O'CONNOR found it significant that a paternity suit was "one of the few Texas causes of action not tolled during the minority of the plaintiff." *Id.*, at 104 (footnote omitted). She stated:

> "Of all the difficult proof problems that may arise in civil actions generally, paternity, an issue unique to illegitimate children, is singled out for special treatment. When this observation is coupled with the Texas Legislature's efforts to deny illegitmate children any significant opportunity to prove paternity and thus obtain child sup-

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ute. *Mills* v. *Habluetzel*, 456 U. S., at 97.

[9] THE CHIEF JUSTICE, JUSTICE BRENNAN, and JUSTICE BLACKMUN joined JUSTICE O'CONNOR's concurring opinion. *Mills* v. *Habluetzel*, 456 U. S., at 102. JUSTICE POWELL joined Part I of JUSTICE O'CONNOR's concurring opinion, but did not join the Court's opinion. *Id.*, at 106 (POWELL, J., concurring in the judgment).

[10] JUSTICE O'CONNOR wrote separately because she feared that the Court's opinion might "be misinterpreted as approving the 4-year statute of limitation now used in Texas." *Mills* v. *Habluetzel*, 456 U. S., at 102 (O'CONNOR, J., concurring).

> port, it is fair to question whether the burden placed on illegitimates is designed to advance permissible state interests." *Id.*, at 104–105.

Finally, JUSTICE O'CONNOR suggested that "practical obstacles to filing suit within one year of birth could as easily exist several years after the birth of the illegitimate child." *Id.*, at 105. In view of all these factors, JUSTICE O'CONNOR concluded that there was "nothing special about the first year following birth" that compelled the decision in the case. *Id.*, at 106.

Against this background, we turn to an assessment of the constitutionality of the two-year statute of limitations at issue here.

## III

Much of what was said in the opinions in *Mills* is relevant here, and the principles discussed in *Mills* require us to invalidate this limitations period on equal protection grounds.[11]

Although Tennessee grants illegitimate children a right to paternal support, Tenn. Code Ann. § 36–223, and provides a mechanism for enforcing that right, § 36–224(1), the imposition of a two-year period within which a paternity suit must be brought, § 36–224(2), restricts the right of certain illegitimate children to paternal support in a way that the identical right of legitimate children is not restricted. In this respect, some illegitimate children in Tennessee are treated differently from, and less favorably than, legitimate children.

Under *Mills*, the first question is whether the two-year limitations period is sufficiently long to provide a reasonable opportunity to those with an interest in illegitimate children to bring suit on their behalf. 456 U. S., at 99. In this regard, it is noteworthy that § 36–224(2) addresses some of the practical obstacles to bringing suit within a short time after the child's birth that were described in the opinions in *Mills*. See 456 U. S., at 100; *id.*, at 105–106 (O'CONNOR, J., concurring). The statute creates exceptions to the limitations period if the father has provided support for the child or has acknowledged his paternity in writing. The statute also allows suit to be brought by the State or by any person at any time prior to a child's eighteenth birthday if the child is, or is liable to become, a public charge. See n. 1, *supra*. This addresses JUSTICE O'CONNOR's point in *Mills* that a State has a strong interest in preventing increases in its welfare rolls. 456 U. S., at 103–104 (concurring opinion). For the illegimate child whose claim is not covered by one of the exceptions in the statute, however, the two-year limitations period severely restricts his right to paternal support. The obstacles to filing a paternity and child support suit within a year after the child's birth, which the Court discussed in *Mills*, see *id.*, at 100; n. 7, *supra*, are likely to persist during the child's second year as well. The mother may experience financial difficulties caused not only by the child's birth, but also by a loss of income attributable to the need to care for the child. Moreover, "continuing affection for the child's father, a desire to avoid disapproval of family and community, or the emotional strain and confusion that often attend the birth of an illegitimate child," 456 U. S., at 100, may inhibit a mother from filing a paternity suit on behalf of the child within two years after the child's birth. JUSTICE O'CONNOR suggested in *Mills* that the emotional strain experienced by a mother and her desire to avoid family or community disapproval "may continue years after the child is born." *Id.*, at 105, n. 4 (concurring opinion).[12] These considerations compel a conclusion that the two-year limitations period does not provide illegitimate children with "an adequate opportunity to obtain support." *Id.*, at 100.

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[11] In this light, we need not reach Pickett's due process challenge to the statute.

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[12] Problems stemming from a mother's emotional well-being are of particular concern in assessing the validity of Tennessee's limitations period because § 36–224(1), see n. 2, *supra*, permits suit to be filed only by the mother or by her personal representative if the child is not likely to become a public charge. As the Tennesssee Supreme Court stated, § 36–224(1)

The second inquiry under *Mills* is whether the time limitation placed on an illegitimate child's right to obtain support is substantially related to the State's interest in avoiding the litigation of stale or fraudulent claims. *Id.*, at 99–100. In this case, it is clear that the two-year limitations period governing paternity and support suits brought on behalf of certain illegitimate children does not satisfy this test.

First, a two-year limitations period is only a small improvement in degree over the one-year period at issue in *Mills.* It, too, amounts to a restriction effectively extinguishing the support rights of illegitimate children that cannot be justified by the problems of proof surrounding paternity actions. As was the case in *Mills*, "[w]e can conceive of no evidence essential to paternity suits that will be lost in only [two years], nor is it evident that the passage of [24] months will appreciably increase the likelihood of fraudulent claims." *Id.*, at 101 (footnote omitted).

Second, the provisions of § 36–224(2) undermine the State's argument that the limitations period is substantially related to its interest in avoiding the litigation of stale or fraudulent claims. As noted, see *supra*, at ——, § 36–224(2) establishes an exception to the statute of limitations for illegitimate children who are, or are likely to become, public charges. Paternity and support suits may be brought on behalf of these children by the State or by any person at any time prior to the child's eighteenth birthday. The State argues that this distinction between illegitimate children receiving public as-

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"does not permit an action to be brought by the child except in case of death or disability of the mother." 638 S. W. 2d, at 380. The Texas statute involved in *Mills* permitted suit to be brought by " 'any person with an interest in the child'. . . ." *Mills* v. *Habluetzel*, 456 U. S., at 100. See also Tr. of Oral Arg. 31–33.

sistance and those who are not is justified by the State's interest in protecting public revenue. See Brief for Appellee 26–30. Putting aside the question of whether this interest can justify such radically different treatment of two groups of illegitimate children,[13] the State's argument does not address the different treatment accorded illegitimate children who are not receiving public assistance and legitimate children. This difference in treatment is allegedly justified by the State's interest in preventing the litigation of stale or fraudulent claims. But as the exception for children receiving public assistance demonstrates, the State perceives no prohibitive problem in litigating paternity claims throughout a child's minority. There is no apparent reason why claims filed on behalf of illegitimate children who are receiving public assistance when they are more than two years old would not be just as stale, or as vulnerable to fraud, as claims filed on behalf of illegitimate children who are not public charges at the same age. The exception in the statute, therefore, seriously undermines the State's argument that the different treatment accorded legitimate and illegitimate children is substantially related to the legitimate state interest in preventing the prosecution of stale or fraudulent claims and compels a conclusion that the two-year limitations period is not substantially related to a legitimate state interest.

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[13] The State unquestionably has a legitimate interest in protecting public revenue. As JUSTICE O'CONNOR pointed out in *Mills*, however, the State also has an interest in seeing that "'justice is done'" by "ensuring that genuine claims for child support are satisfied." 456 U. S., at 103 (concurring opinion). Moreover, an illegitimate child has an interest not only in obtaining paternal support, but also in establishing a relationship to his father. As the Juvenile Court suggested in this case, these interests are not satisfied merely because the mother is providing the child with sufficient support to keep the child off the welfare rolls. App. 16. See n. 4, *supra*. The father's duty of support persists even under these circumstances. App. 16. See also *Rose Funeral Home, Inc.* v. *Julian*, 176 Tenn. 534, 539, 144 S. W. 2d 755, 757 (1940); *Brooks* v. *Brooks*, 166 Tenn. 255, 257, 61 S. W. 2d 654 (1933). In any event, we need not resolve this tension in this case. As we discuss *infra*, the State's interest in protecting the public revenue does not make paternity claims any more or less stale or vulnerable to fraud.

Third, Tennessee tolls most actions during a child's minority. See Tenn. Code Ann. § 28-1-106 (1980).[14] In *Parlato* v. *Howe*, 470 F. Supp. 996 (ED Tenn. 1979), the court stated that "[t]he legal disability statute represents a long-standing policy of the State of Tennessee to protect potential causes of action by minors during the period of their minority." *Id.*, at 998–999. In view of this policy, the court held that a statute imposing a limitations period on medical malpractice actions "was not intended to interfere with the operation of the legal disability statute." *Id.*, at 998. Accord, *Braden* v. *Yoder*, 592 S.W. 2d 896 (Tenn. App. 1979). But see *Jones* v. *Black*, 539 S.W. 2d 123 (Tenn. 1976) (one-year limitations period governing wrongful death actions applies "regardless of the minority or other disability of any beneficiary of the action"). Many civil actions are fraught with problems of proof, but Tennessee has chosen to overlook these problems in most instances in favor of protecting the interests of minors. In paternity and child support actions brought on behalf of certain illegitimate children, however, the State instead has chosen to focus on the problems of proof and to impose on these suits a short limitations period. Although the Tennessee Supreme Court stated that the inapplicability of the tolling provision to paternity actions did not "alone" require invalidation of the limitations period, 638 S. W. 2d, at 380, it is clear that this factor, when considered in combination with others already discussed, may lead one "to question whether the burden placed on illegitimates is designed to advance permissible state interests." 456 U. S., at 105 (O'CONNOR, J., concurring). See also *id.*, at 106 (POWELL, J., concurring in the judgment).[15]

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[14] Tennessee Code Ann. § 28-1-106 (1980) reads as follows:

"If the person entitled to commence an action is, at the time the cause of action accrued, either within the age of eighteen (18) years, or of unsound mind, such person, or his representatives and privies, as the case may be, may commence the action, after the removal of such disability, within the time of limitation for the particular cause of action, unless it exceed three (3) years, and in that case within three (3) years from the removal of such disability."

Finally, the relationship between a statute of limitations and the State's interest in preventing the litigation of stale or fraudulent paternity claims has become more attenuated as scientific advances in blood testing have alleviated the problems of proof surrounding paternity actions. As JUSTICE O'CONNOR pointed out in *Mills*, these advances have "dramatically reduc[ed] the possibility that a defendant will be falsely accused of being the illegitimate child's father." *Id.*, at 104, n. 2 (concurring opinion). See *supra*, at ——. See also *Little* v. *Streater*, 452 U. S. 1, 6–8, 12, 14 (1981). Although Tennessee permits the introduction of blood test results only in cases "where definite exclusion [of paternity] is established," Tenn. Code Ann. § 36–228 (1977); see also

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[15] There is some confusion about the relationship between § 28–1–106 and § 36–224. Compare Brief for Appellant 18; Tr. of Oral Arg. 10, 13 with Brief for Appellee 13–14, 18; Tr. of Oral Arg. 30–31, 37–38. Even assuming that the limitations period in § 36–224(2) is tolled during the mother's minority, the important point is that it is not tolled during the minority of the child. As noted, see *supra*, at ——, and n. 14, statutes of limitations generally are tolled during a child's minority. This certainly undermines the State's argument that the different treatment accorded legitimate and illegitimate children is justified by its interest in preventing the litigation of stale or fraudulent claims.

It is not critical to this argument that the the right to file a paternity action generally is given to the mother. It is the child's interests that are at stake. The father's duty of support is owed to the child, not to the mother. See Tenn. Code Ann. § 36–223 (1977). Moreover, it is the child who has an interest in establishing a relationship to his father. This reality is reflected in the provision of § 36–224(1) that allows the child to bring suit if the mother is dead or disabled. Cf. S. Rep. No. 93–1356, p. 52 (1974) ("[T]he interest primarily at stake in [a] paternity action [is] that of the child"). Restrictive periods of limitation, therefore, necessarily affect the interests of the child and their validity must be assessed in that light.

§24–7-112 (1980), it is noteworthy that blood tests currently can achieve a "mean probability of exclusion [of] at least . . . 90 percent. . . ." Miale, Jennings, Rettberg, Sell & Krause, Joint AMA-ABA Guidelines: Present Status of Serologic Testing in Problems of Disputed Parentage, 10 Family L. Q. 247, 256 (1976).[16] In *Mills*, the Court rejected the argument that recent advances in blood testing negated the State's interest in avoiding the prosecution of stale or fraudulent claims. 456 U. S., at 98, n. 4. It is not inconsistent with this view, however, to suggest that advances in blood testing render more attenuated the relationship between a statute of limitations and the State's interest in preventing the prosecution of stale or fraudulent paternity claims. This is an appropriate consideration in determining whether a period of limitations governing paternity actions brought on behalf of illegitimate children is substantially related to a legitimate state interest.

## IV

The two-year limitations period established by Tenn. Code Ann. §36–224(2) does not provide certain illegitimate children with an adequate opportunity to obtain support and is not substantially related to the legitimate state interest in preventing the litigation of stale or fraudulent claims. It therefore denies certain illegitimate children the equal protection of the laws guaranteed by the Fourteenth Amendment. Accordingly, the judgment of the Tennessee Supreme Court is reversed and the case is remanded for proceedings not inconsistent with this opinion.

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[16] See also Stroud, Bundrant, and Galindo, Paternity Testing: A Current Approach, 16 Trial 46 (Sept. 1980) ("Recent advances in scientific technology now enable the properly equipped laboratory to routinely provide attorneys and their clients with a 95–98 percent probability of excluding a man falsely accused of paternity"); Terasaki, Resolution By HLA Testing of 1000 Paternity Cases Not Excluded By ABO Testing, 16 J. Family L. 543 (1978). See generally Ellman and Kaye, Probabilities and Proof: Can HLA and Blood Group Testing Prove Paternity?, 54 N. Y. U. L. Rev. 1131 (1979).

*It is so ordered.*

Senator DURENBERGER. Are any or all of you familiar with the provisions of S. 888, which is the Economic Equity Act, and its provisions for child support? And if so, would you have any general comments on the thrust of the child support portions of the Economic Equity Act?

We are having the first hearing on it in this committee on Monday of next week, and after making you wait for a couple of hours, we would hate to have you to come back and testify in favor of it.

But do you have any general comments? We would appreciate it.

Mr. COPELAND. Certainly.

I think maybe the most important aspect of that is in the purpose statement, in the statement that the service is to be available to every child living with a single parent.

There are several of us that feel the current statute language makes that requirement right now, but OCSE, the Federal Office of Child Support, has continuously made the effort to direct the program to the AFDC reimbursement group.

I would like this committee to take a look at the direction that the Federal Office of Child Support has tried to take the program, and provide the funding that would give the word to the Federal Office that both programs are really important.

The purpose statement came about primarily in response to the administration's effort to turn the program into the AFDC areas, and I think that's one of the primary things that we would like you to recognize.

Senator DURENBERGER. Any other comments from the panel? Ms. Hummel?

Ms. HUMMEL. I would just like to encourage the committee when reviewing this to understand that women in general have been very discouraged about child support enforcement, and in making policy decisions as to its direction I think we need to not continue to give false hope to the women of this country in this particular area. If we have not the resources, we need to make clearer statements in regard to what the Government's participation should really be.

Senator DURENBERGER. Thank you very much.

Senator Long, do you have a question?

Senator LONG. I would like to ask Ms. Hummel this: As I recall it, under the law we passed in 1975 we gave the child support authorities the right to go into Federal court when all else fails in trying to reach fathers who fled across State boundaries to try to avoid their responsibilities toward their children. My understanding is that this authority has never been used, to take the matter into Federal court.

What are some of the problems you face in enforcing support on an interstate basis? And can you give us some specific recommendations about ways we might improve on interstate collection?

Ms. HUMMEL. In regard to interstate collection, I think in the first aspect as far as the Federal courts, we have been somewhat discouraged on the legal aspects of the cumbersomeness of that particular remedy.

I feel States have been trying to work toward finding ways of complementing one another versus putting themselves in an adversary role of one State against another.

As far as interstate activities, we need to upgrade ERISA laws within each State. I believe that the office of child support enforcement could influence this particular aspect. If you examine the particular laws, many of them are not as progressive. Some States have had very limited success in trying to procure extensive upgrading of their particular law in that area.

So consequently there is an element of fragmentation between what you all have to go through in one State—like, for instance, one State might only talk about current child support; they have certain remedies as far as the funding; and so consequently it becomes confusing and very cumbersome.

Senator LONG. Any of the others?

Mr. COPELAND. Yes, sir. Each year the Federal audit group comes out and audits our program, and their beginning statement deals with the fact that we collected so much money and spend so much money. And each year my response to this official document refers to the fact that they have the collections for the State of Alaska understated, traditionally, by approximately 20 percent. That's because they simply do not reflect the fact that the State of Alaska collects a large amount of money and sends it to other States.

There are a lot of other States that are just in the other position—they receive a lot more money from other States, and so their collections-to-expenditure ratios appear far better than the State of Alaska, simply because of the way the statistics are presented.

Now, as a program manager this is an extremely difficult position for me to be in, to try to explain my collections which are presented 20 percent short when my expenditures are presented to include the cost of doing those.

That is just a very basic elemental problem that I have got to deal with, and it's hard to explain to someone on the outside, "Well, really those figures aren't accurate," because every program manager says that about any audit of themselves. But all of a sudden when I am looking at a set of requirements that require me to do certain things, and then you might say the "scorecard" comes out without the benefit of those, it is extremely difficult in addition to interstate activities where you have got conflicting legal requirements.

Mr. ABBOTT. Yes, sir. I would like to comment on that briefly.

I think, in terms of what this committee can do to enhance the interstate coordination effort, the best thing that could be done would be to reject the performance funding proposal. That proposal would be the best news for fathers who don't want to pay their child support that will be coming down for quite a while. The reason is that it will create havens throughout the country in various areas because it is simply a matter of you don't have enough people to work all the cases you presently have, so you prioritize out the difficult cases. Difficult cases are traditionally those where you don't know where the father is and you have to do an ERISA to find out if you can get support from him if and when you ever do find him.

So there are many long-term overhauls that should be considered. Mandatory wage assignments would go a long way in that direction.

If the States had similar laws and similar remedies to bring about support payments, I think that we would all be able to work more harmoniously together and eliminate some of these problems that exist.

Senator **Long**. Well, I think we ought to understand that when we are trying to obtain support for children who are not on the welfare rolls, that cost should not be counted in deciding how efficient you are in collecting for those who are on the welfare rolls.

Now, some people seem to overlook that these mothers who are not on the welfare rolls are taxpayers. They are doing us a big favor to pay those taxes. They are entitled to some service from their government. And those fathers we are pursuing are lawbreakers—they are in violation of the law and getting away with it.

Now, it is the burden of society to pay the expense of courts, to pay for prosecuting attorneys, to pay for lawyers to represent the people who are the victims of law violations, and to pay to provide services to honest legitimate taxpayers who are trying to do what is right for themselves and their families and for society.

So it is absolutely wrong to take the view that, unless this program is making a father pay to help keep his family off welfare, unless it is showing a profit, it shouldn't be done at all. Those who take that view are totally overlooking the fact that by pursuing these people we tend to create an atmosphere where people will tend to pay up. They will do so because they know that, if they don't pay, somebody is going after them.

You agree with this, I take it, all of you?

Mr. **Copeland**. Absolutely.

Mr. **Abbott**. Absolutely.

Senator **Long**. Thank you.

Senator **Durenberger**. Thank you very much.

Thank you all, panelists. We appreciate your patience and your testimony.

The next panel consists of Michael E. Barber, supervising deputy district attorney for domestic relations, office of the district attorney, Sacramento, Calif., on behalf of the American Bar Association; Ms. Sue Hunter, president of the Louisiana Child Support Enforcement Association, from Gretna, La.

We have a two-person panel. Thank you very much.

I think, Michael, we are going to start with you. Your statements will all be made part of the record in full, and you may summarize.

Mr. **Barber**. Yes, sir.

## STATEMENT OF MICHAEL E. BARBER, ESQ., SUPERVISING DEPUTY DISTRICT ATTORNEY FOR DOMESTIC RELATIONS, OFFICE OF THE DISTRICT ATTORNEY, SACRAMENTO, CALIF. ON BEHALF OF THE AMERICAN BAR ASSOCIATION, WASHINGTON, D.C.

Mr. BARBER. Mr. Chairman, members of the committee.

I want to thank the committee for the opportunity to present this testimony to you on behalf of the American Bar Association.

I am Michael E. Barber—Mike Barber—council member of the section of family law. I am here on behalf of the president of the American Bar Association, Morris Harrell, and the chairman of the family law section, Samuel Schoonmaker III, to oppose what we understand to be the administration's fiscal year 1983–84 proposal for altering and unbalancing the funding structure for enforcement of family support obligations under title IV–D of the Social Security Act.

The American Bar Association has had a long and continuous history, and particularly the family law section of that organization has had a long and continuous history of support for the title IV–D program. Representatives of that organization spoke on behalf of it early on in HHS-sponsored training sessions right when the program got started in 1975. They have worked and passed resolutions concerning cooperation with the program, supporting nonwelfare funding, and of course the present resolution that is before you in my testimony. It is for several reasons that they have taken this position:

One, of course the American Bar Association is dedicated to equal protection under the law. The economic situation that is created for a mother—and 90 percent of your cases involve mothers—abandoned with two children, without the resources to adequately enforce support for those children is such that the economic dynamics of it without government throwing itself into it creates an imbalance and lack of equal protection.

Second, of course the conservation that every citizen wants to make in terms of public resources, to conserve and protect public resources so that they can be protected and invested properly for governmental purposes and not used for what is essentially a private responsibility, the support of one's own children.

The Federal program has heretofore been extremely effective in going forward with these goals—it substituted for the NOLEO program that was in there before—oriented in the same way that the restructuring proposal would go, oriented solely toward collections on the welfare.

This committee found, and the GAO found, NOLEO to be ineffective and costing everybody more money than it was worth, but from 1975 forward the program has had a significant and positive impact in a number of areas. Let me give you some figures—I believe I've got them available here—about the impact over a very short period of time on the nonwelfare side:

In Oregon, between 1973 and 1975, Oregon's basic AFDC caseload rose from 20,000 to 31,000 and reached in April of 1978 a high of 38,000. It was projected it would climb to 53,000 by 1981. In fact it has never again exceeded the April 1978 level, at least as of the time this was written in 1982.

Shelby County, Tenn., reported its welfare caseload dropped 30 percent in the first year of IV-D:

Nevada saw its AFDC caseload drop from 3,200 to 2,300 between 1975 and 1978, instead of climbing to a projected 6,000 cases.

Clay County, Mo., submitted a letter along with testimony that I submitted last year in opposing this same program that shows how deeply they cut into the AFDC roles

In California, with the program that became the pilot program for IV-D, we saw a significant cut.

Thus, AFDC is cut by nonwelfare but given no credit, virtually no credit, in the administration's proposal.

However, you have heard about interstate, let me go to paternity just briefly:

Paternity is a long-term investment in terms of the program. A paternity case involves someone who is younger, someone who doesn't quite have the resources at the present time to pay. And yet if you don't strike while the iron is hot, the evidence gets cold. I'm sure Senator Long as a practicing attorney will know that and relate to it.

If we delay until someone can pay, which is the implied thrust of the administration proposal, we lose the case. And it is not fair to the father. The individual develops other obligations, other family obligations, and reliance on the idea that people are going to abandon the case and not ever bother him again. And thus, when it comes time to have resources to pay, he can't.

It is our suggestion, the American Bar's suggestion in here, then, that in reporting in the future, OCSE be required to separately state paternity costs and not to state those as part of the program effectiveness evaluation.

Finally, it should be pointed out that their whole concept of program effectiveness is inappropriately focused. Let us suppose that—miracle of miracles—IV-D got everybody off of AFDC. We started to collect all of those grants. We would be totally ineffective under the OCSE proposal, because there would be no more welfare dollars that could be plugged back into the program. Even if we get a percentage of those cases off of aid, the savings in administrative costs alone are enormous. In California it costs you $115 a year on the average to run a child support case, a IV-D case. In California it costs you $484 a year to run a IV-A case. We get no credit for that in the OCSE restructuring proposal, in any of their statistics that they submitted to you, or anyplace else. Mr. Copeland has hit hard the omissions in their report. At the price of being redundant, let me just underline what he said and bring that statistic up to you as well.

Let me conclude by reading into the record my summary statement on page 7:

The funding structure of child support enforcement developed in 1975 has proven to be quite effective. The present structure has returned to the taxpayer a constant and significant sum. It has saved the taxpayer millions more in welfare grants and the enormous cost of administration thereof. By protecting the rights of single parents who have been left without funds but with children to raise, it has given meaning to our constitutional promise of equal justice under law.

Finally, it meets a basic obligation of government protecting the underlying rights of the politically weakest and those least able to defend themselves, the out-of-wedlock infant. The American Bar Association calls upon Congress to continue this most effective program and to maintain the funding structure and levels in effect in August of 1982.

President Reagan stated in his state of the Union message for 1983: "We intend to strengthen enforcement of child support laws to insure that single parents, most of whom are women, do not suffer financial hardship." This can best be accomplished by reinforcing and strengthening the present funding system, retaining the 15-percent incentive, restoring 75-percent reimbursement not only for single parents but most of all for the children of single parents who most urgently need a renewal of your commitment to protecting their family rights.

On behalf of the American Bar Association and its family law section I thank the chairman and the committee for permitting me to present these views.

Senator **DURENBERGER**. Thank you very much, Mr. Barber. Next will be Ms. Hunter.

[Mr. Barber's prepared statement follows:]

### STATEMENT OF MICHAEL E. BARBER, COUNCIL MEMBER, SECTION OF FAMILY LAW, ON BEHALF OF THE AMERICAN BAR ASSOCIATION

Mr. Chairman and members of the committee, I want to thank the Committee for the opportunity to present this testimony to you on behalf of the American Bar Association. I am Michael E. Barber, Council Member of the Section of Family Law. I am here on behalf of the President of the American Bar Association, Morris Harrell, and Chairman of the Family Law Section, Samuel Schoonmaker III, to oppose the Administration's fiscal year 1983–84 proposal for altering the funding system for enforcement of family support obligations under Title IV–D of the Social Security Act.

In 1982, in preparation for the 1982–83 budget, the Office of Child Support Enforcement proposed doing away with the balanced approach to funding the system for enforcement of family support obligations under Title IV–D of the Social Security Act by diverting efforts totally to recoupment in welfare cases. This was done by making funding and thus jobs totally dependent on that narrow segment of responsibility under Title IV–D of the Social Security Act. In response, the House of Delegates of the ABA adopted in August of 1982, the attached resolution. Unfortunately, because the schedule of the House of Delegates permitted no earlier action, the resolution came after some spending cuts took place. However, the program insight embodied in this resolution was also similarly accepted by both houses of Congress, each of which rejected the Office of Child Support Enforcement's poorly framed proposal. It is our understanding O.C.S.E. is back this year with the same ill founded scheme. The American Bar Association calls upon Congress to continue its commitment to the protection of the rights of all children to support. It further calls upon Congress to restore funding at the percentages effective on the date of its resolution, August 1982. By doing so, Congress not only will be protecting the rights of children but also those of the taxpayer.

The present structure pays a percentage of the cost of child support enforcement (70 percent now, was 75 percent in August of 1982) and gives the enforcing jurisdiction 15 percent (to be dropped to 12 percent in October, 1983) of that portion of the collection that repays the taxpayer for having supported the family under Title IV–A of the Social Security Act. The O.C.S.E. scheme would drop partial cost reimbursement (the 70 percent and instead leave with the enforcing jurisdiction enough of its collections on IV–A cases to cover its cost, returning approximately one half the remainder to the federal government. (This, of course, assumes there will be a remainder). There are in this scheme bonuses provided for to improve performance. However, the bonus is paid long after the event on which the bonus is based or the bonus is based on interstate competition, or both of the above. In any of these cases, the scheme provides no funds on which a community can plan a budget and thus the scheme provides a state or local government with no real incentive to perform better.

Prior to January of 1975, the federal child support program had as its focus the same focus as the O.C.S.E. proposal, collecting reimbursement for IV–A (i.e., A.F.D.C. or welfare) expenditures. There was no non-welfare aspect to that program. There was no reimbursement for interstate effort. There was no cost reimbursement for paternity cases. As a result, the General Accounting Office found there was no effective program and the taxpayer was losing money. It was because this narrowly focused effort was such a failure that Congress enacted IV–D with its broad and distinctive mandates. These are to collect reimbursement for IV–A expenditures, to enforce support for all children of single parent households, to do this in interstate cases, and to prove parentage regardless of any cost saving thereby.

The results were spectacular. In 1975, according to census figures, 1.2 million single parent households received some absent parent support. By 1978, this had gone up to 2.2 million, an 80 percent increase. President Ford in 1976 was able to announce a decline in IV–A activity, the first in forty years, attributable to the child support enforcement program. Paternity establishment per year has climbed by 50 percent since 1978, from 111,000 in that year to 174,000 in fiscal 1982. And the taxpayer has profited, albeit at an uneven rate. The following table shows how total program costs compare with collections of just funds that offset IV–A costs:

| | Collections (for IV–A) | Total cost | Taxpayer saving |
|---|---|---|---|
| 1978 | $471,567,463 | $312,339,447 | $169,339,447 |
| 1979 | 596,626,441 | 359,859,585 | 236,716,854 |
| 1980 | 603,084,291 | 449,513,175 | 153,571,116 |
| 1981 | 670,637,925 | 512,530,865 | 158,107,060 |
| 1982 | 787,317,640 | 592,368,278 | 194,949,362 |

The return to the taxpayer has been increasing for the last three years at a higher and higher rate. Thus, in 1982, while overall return on the taxpayer investment was 32 percent, the return on the added investment between 1981 and 1982 was 45 percent. Were the government to put taxpayer funds in a money market account, the return would bave been substantially lower.

It has been and continues to be a complaint of most states, including California, which is my residence, that the above analysis is too narrowly focused because it fails to take into consideration the cost avoidance aspect of the support enforcement program. Collections for families not receiving A.F.D.C. have increased from $575,122,989 in 1978 to $984,164,296 in 1982. Child support enforcement agencies estimate that 65 to 75 percent of their non-welfare cases involve former IV–A recipients. A study by Lenore Weitzman in the U.C.L.A. Law Review (August of 1981, page 1181) demonstrates that for a single parent with custody, divorce is an economic disaster, leaving that parent, at best, with only half of the per capita income available during the marriage. Welfare dependence is all too common, and inevitable unless child support can be collected. Thus, savings on A.F.D.C. grants are considerable. O.C.S.E., with a very limited view of the savings, was able to verify in 1982 a taxpayer saving of $94.1 million in the non-welfare program. This was just in A.F.D.C. grants. It is submitted that had it sampled cases of persons who were never on A.F.D.C. (another name for Title IV–A) and had data available from all fifty states, the amount of welfare funds saved would have been many times larger.

Office of Child Support Enforcement also understates this figure by failing to consider savings on administrative costs. In California, it costs four times as much per year to supervise a IV–A case ($484) than it costs to supervise a IV–D case ($115). By being able to keep a welfare case closed, the taxpayer saves $333 per year per case. While costs do vary nationwide, assuming we could turn all IV–A support related cases into non-welfare cases, applying California administrative costs, the taxpayer would save $1.8 billion in administrative costs alone. While this goal is unrealistic, if only a third of the welfare cases could be taken of the rolls the savings in administrative costs alone would exceed the total cost of Title IV–D. This administrative saving also points out a basic flaw in O.C.S.E.'s proposal, since under their proposal it would no longer be worthwhile to enforce support for non-welfare families. In fact, the O.S.C.E. proposal provides an incentive for keeping cases in the IV–A program (on the welfare rolls) for as long as possible, with all that means in terms of welfare department's cost of administration of those cases.

It should be added that, not only would there be a fiscal incentive to keep up the IV-A rolls, there would be no incentive to try to help other states cut their rolls. Even in the present structure, this is a weak part of the program since 30 percent (formerly 25 percent of the cost of this enforcement is borne by the locality where the absent parent lives, and there is little practical incentive outside a sense of duty to take these cases as seriously as one where both parties are local. O.C.S.E.'s proposal would be a fiscal disincentive to doing anything on such cases. This country has almost eliminated haven states for parents fleeing support obligations. O.C.S.E. would restore them.

Perhaps the greatest damage of all is that which would be done relating to paternity. The title of Part D is "Child Support and Establishment of Paternity." It is a separately stated program mandated under 42 U.S.C. 651, 652(a)(1), 654(4)(A) and 655(a), without regard to enforcement. And it has been a success. Since 1977, the number of paternities established per year have grown from 110,000 to 174,000 in 1982. It has had a very positive effect on child support enforcement. Because of the IV-D program, blood tests, tissue tests or both are now admitted to prove parentage in over 36 states, more than double the pre 1975 total. U.S. Supreme Court cases have been litigated on statutes of limitations successfully protecting out of wedlock children's rights to support. These would have gone unchallenged per Title IV-D. The growing rate of out of wedlock births (10 percent of all live births in the early 1970's, 17 percent in 1982) has created a significant challenge for the enforcement agency. The challenge has been met, but not without a cost. Yet O.C.S.E. in its mandated report to Congress under 42 U.S.C. 652(a)(1)) buries this separate cost within the overall program administration costs, and then implies that support enforcement is less than cost effective.

For the good of out of wedlock children, not only should O.C.S.E.'s proposal be dropped and funding set at August, 1982 rates, but 42 U.S.C. 652(a)(10) should be amended to prevent H.H.S. and O.C.S.E. from commingling the funding of this separate program with child support enforcement. Cost effevtive ratios should be confined to costs of enforcement, not paternity. This reform, it is submitted, would make it clear that support enforcement is profitable not only to the taxpayer, but to each of the entities through which the taxpayer works, the local, state and federal governments. This reform would cost nothing save a few extra pages in O.C.S.E.'s annual report.

In summary, the funding structure of child support enforcement developed in 1975 has proven to be quite effective. The present structure has returned to the taxpayer a constant and significant sum. It has saved the taxpayer millions more in welfare grants and the enormous cost of administration thereof. By protecting the rights of single parents who have been left without funds but with children to raise, it has given meaning to our constitutional promise of equal justice under law.

Finally, it meets a basic obligation of government protecting the underlying rights of the politically weakest and those least able to defend themselves, the out of wedlock infant. The American Bar Association calls upon Congress to continue this most effective program and to maintain the funding structure and levels in effect in August of 1982.

President Reagan stated in his State of the Union message for 1983:

"We intend to strengthen enforcement of child support laws to ensure that single parents, most of whom are women, do not suffer financial hardship."

This can best be accomplished by reinforcing and strengthening the present funding system, retaining the 15 percent incentive, restoring 75 percent reimbursement not only for single parents but most of all for the children of single parents who most urgently need a renewal of your commitment to protecting their family rights.

On behalf of the american Bar Association, and its Family Law Section, I thank the Chairman and the Committee for permitting me to present these views.

### APPENDIX A.—RESOLUTION OF THE HOUSE OF DELEGATES OF THE AMERICAN BAR ASSOCIATION, ADOPTED AUGUST, 1982

*Resolved* That the American Bar Association calls upon Congress to maintain the funding system for enforcement of family support obligations presently in effect in Title IV-D of the Social Security Act, save and except the right to charge fees for such services be left up to the individual states.

## APPENDIX B.—TITLE IV-D OF THE SOCIAL SECURITY ACT

### B. CHILD SUPPORT ENFORCEMENT (CSE) (TITLE IV-D) LEGISLATIVE INITIATIVES

NOTE.—The administration has not submitted its legislation for the child support enforcement program. The following descriptions are taken from the President's fiscal year 1984 Budget. Modifications to the budget proposal are reportedly under consideration.

*1. Restructure Federal Matching Provisions*

*Current law.*—The Federal Government pays 70 percent of State and local administrative costs for child support services to both AFDC and non-AFDC families. (The matching rate was reduced from 75 percent beginning in fiscal year 1983 by the Tax Equity and Fiscal Responsibility Act of 1982.) Where the absent parent's family is receiving AFDC, and child support that is collected is used to offset AFDC benefit costs. An additional 15 percent incentive payment financed solely out of the Federal share of collections is also made to States and localities which make collections on behalf of an AFDC family. (The incentive payment is reduced to 12 percent starting in 1985 by that same Act.)

*Proposal.*—The administration proposes that funding for the program be provided by AFDC child support collections. States would apply their administrative expenses for services to AFDC families against child support collections on behalf of AFDC recipients. The residual net collections, whether positive or negative, would then be divided between the State and Federal governments according to the State AFDC matching rate. Bonus payments would be alloted according to standards determined by the Secretary in the following three areas: (1) child support collections for AFDC families; (2) program cost effectiveness; and (3) cost avoidance program savings. The standards for measuring performance in these three categories would be reviewed at least once every two years.

Funding for automated data processing systems would be authorized through project grants, rather than by the 90 percent Federal matching formula in present law.

The new financing mechanism would be phased in over three years. During the first 2 years, States would have the option of receiving funding under the new proposal, or of receiving a level of funding equivalent to 75 percent of what they could have received under the prior law in fiscal year 1984 or 50 percent of their prior law funding in fiscal year 1985.

This financial restructuring proposal without a phase-in was submitted to Congress in 1983, but was not agreed to by the committee.

## STATEMENT OF SUE HUNTER, PRESIDENT, LOUISIANA CHILD SUPPORT ENFORCEMENT ASSOCIATION, GRETNA, LA.

Ms. HUNTER. Thank you.

Mr. Chairman and members of this committee, thank you very much for this opportunity to speak to you about our concerns.

I am Sue Hunter. I am administrator of the support enforcement division of District Attorney John M. Mamoulides in Jefferson Parish, La. I am speaking for the Louisiana District Attorneys Association and the Louisiana Association of Child Support Enforcement in expressing our views to oppose performance funding.

We have not yet seen the details, and as we learned today they are not yet available; but from what we know it would simply be the death knell for those of us who are working in the local program.

They say in the Federal projections that Louisiana would save $5,200,000 by their performance funding. Our State agency projected $740,000 savings. Now, that is six times more than our State agency is projecting—taking our collections and our expenditures, we come up with $740,000.

Now, it is obvious that they didn't consult the local people when they made that proposal, and they don't know what it takes to make collections. It could be that this is underestimated by as much as $338 million.

Now, even that $740,000 assumes that the local governments are going to come up with 30 percent match and that the D.A.'s—the district attorneys—would be able to work without any incentives.

Our local governments regard this as a State issue if not a national concern. They can't solve the problems at the local level, so they are not willing to commit any more funds to it. Our local governments are still matching at only a rate of 25 percent.

The local governments and the district attorneys would lose $1,350,000, while the State was saving that $740,000. We are having problems even with the cutback now.

So we are negotiating with the people at the State level to continue our contract relationship at the pre-1982 level. I hope it works, because if it doesn't the scenario for the performance funding really looks bad. In other words, if the district attorneys no longer participate in the program, then instead of the State having any savings at all they will lose over $3 million in State money. This means that Louisiana will have to spend twice as much State money to collect one-third as much money, because if we pull out the they will only collect 36 percent of what they have been collecting.

If this is the Louisiana picture, has anyone looked at the variables in all the other States—the State laws, how they are operated, and that the programs that are operated—to see what the real implications of this performance funding may be? Because it may very well end up that, instead of there being a saving to the taxpayer, the Federal Government is really going to have more problems.

If this program is destroyed in Louisiana, it will take years to rebuild it. We will have to start all over. We are doing good things in Louisiana.

Last year we increased our AFDC collections by 25 percent; we increased our non-AFDC collections by 48 percent; and 60 percent of Louisiana's cases are non-AFDC. We did all of that with an increase in expenditures'of 13.5 percent. So we really want you to oppose this performance funding with us.

Thank you.

Senator **DURENBERGER**. Thank you very much for your testimony, both of you.

[Prepared statements of Sue Hunter and Debi Evans follows:]

## STATEMENT OF SUE P. HUNTER, FOR LOUSIANA DISTRICT ATTORNEYS ASSOCIATION AND LOUISIANA CHILD SUPPORT ENFORCEMENT ASSOCIATION

### SUMMARY

The Jefferson Parish District Attorney, the Louisiana District Attorneys Association and the Louisiana Child Support Enforcement association ask that Congress keep the federal financial participation in the Child Support Enforcement Program at least at the current level of 70 percent federal matching funds and 12 percent incentive.

We opposed performance funding. We believe that sweeping changes in a stable program to an unreliable funding formula will:

1. Dismantle the child support enforcement system at the local level.
2. Make the states hesitant to invest in program enhancements.

3. Adversely affect the program nationwide through reduced services for non-welfare recipients, paternity establishmnent and interstate cases.
4. Cost the federal government and the taxpayer in increased welfare grants.
5. Reduce the momentum to provide more effective service.

Some amendments to Title IV-D to make the program stronger are being proposed in Congress this year. We urge that those changes be given a chance to operate before tampering wit the funding formula.

We recommend that the Regional Offices of the Office of Child Support Enforcement and the Institute of Child Support Enforcement work with individual states in pinpointing problems caused by the variables in program administration in different states. This approach will prove the most efficient in bringing about needed improvements.

## STATEMENT

Mr. Chairman and members of the Senate Finance Committee, thank you for this opportunity to voice concerns about restructuring financing of the Child Support Enforcement Program.

For the past four and a half years I have been Administrator of the Support Enforcement Division of District Attorney John M. Mamoulides in Jefferson Parish, Louisiana. I speak for the Louisiana District Attorneys Association in this matter. I am also President of the Louisiana Child Support Enforcement Association and express their Views. Our Board is composed of state judges, staff members of the Department of Health and Human Resources and of the District Attorneys.

We are proud that a Senator from our State, the Honorable Russell Long, has the insight and vision to assume leadership in establishing the child support enforcement program at the national level.

Although we have not yet seen the final proposal that the Office of Child Support Enforcement is pushing this year, our Association was treated to a preview at our annual meeting last March. After studying it further, we are convinced that adoption of the performance funding would be a death knell to those of us administering the program at the local level.

As we looked at the savings they projected, it became obvious that those doing the numbers had not consulted the people in the field and were not aware of what it really takes to make those collections.

*State savings under performance funding*

| | |
|---|---|
| Fiscal year 1984: | |
| Federal projection | $5,200,000 |
| State projection | 740,000 |

In other words, the federal projection is six times as much as Louisiana's. If the same error was carried through on the national budget, this could mean that savings to the states have been over-estimated as much as $338 million.

The State Agency's projection of $740,000 saving is based on the assumption the local government would pick up the 30% match and that the District Attorneys would continue contracts without any incentives. This may not be so.

Our local governing bodies regard child support at least as a state issue, if not a national concern. They see that the problems cannot all be solved at the local level, so they do not feel that they should commit more local funds to child support, even if they were able to do so.

Negotiations are now under way with the Department of Health and Human Resources for the District Attorneys to share in state savings for the program. We hope this will be successful, for without the District Attorneys as the "enforcers", the producers, the scenario for performance funding looks exceedingly bleak.

STATE SAVINGS UNDER PERFORMANCE FUNDING

| | |
|---|---|
| Federal projection | +$5,200,000 |
| State projection (with D.A.'s) | +740,000 |
| State projection (without D.A.'s) | −3,112,000 |

The end result is that Louisiana would have to spend twice as much state money to collect one third as much money. Is this any way to make a good program better?

We fail to see how the Performance Recognition awards will improve cost effectiveness. Our opposition stems from these points:

1. The awards are a windfall, not a bonus. They cannot be accurately budgeted because the criteria is changed yearly.
2. The awards come the year after collections are made.

3. The awards help those who are already doing well, not those who are struggling to improve.

4. Determination of award require extensive and expensive audits for verification. More jobs would be created at the federal level at the expense of jobs in the field for those who are actually doing the collecting.

5. Our state constitution prohibits borrowing.

We believe the end result of performance funding is destruction of Louisiana's Child Support Enforcement Program because local government cannot absorb the additional cost. With uncertain funding, neither state governments or district attorneys would be willing or able to make additional investments in long term enhancements for a more effective program.

The "Hold Harmless" feature of the proposal would not alleviate the inherent weakness of the performance funding formula.

Without the participation of the district attorneys, a totally new system would have to be devised and implementing the process would take a number of years. In the meantime collections would fall to an all time low, just at the point a good program is headed for a record high in collections.

We seem to have gotten away from the intent of Congress to give child support enforcement services to all children. For the past two years "cost effectiveness" seems to be the total name of the game.

No recognition for cost effectiveness is given for collections made on behalf of non-welfare recipients. Last year 60 percent of our collections were in that category. Sixty-five percent of Louisiana's non-welfare caseload are former recipients of Aid to Families with Dependent Children. Neither do monetary rewards come from refunds to families who are removed from welfare rolls because of support enforcement efforts. Every year 1500 recipients in Louisiana fall in this category.

New statistice appear almost weekly, documenting the changes in society which have occurred even since the 1975 federal law was passed. The growth in out of wedlock births is a rising phenomenon. We should be devoting greater resources to establishing paternity for this generation of children. Establishing paternity is the most expensive thing that we do and is not cost effective in the federal definition of funding.

Other statistics cite the rise in one parent families, 98 percent of which are headed by women. Presently about 20 percent of all families with children are headed by their mothers alone. The official measure of poverty for these families is fully 40 percent—compared to less than 8 percent for families headed by both parents. Most of these families desperately need child support enforcement.

Under the thrust of performance funding, we would be forced to decrease services and inevitably dump more cases back into the walfare system. We believe the federal share of the AFDC grants would increase far more than any savings that could be realized by the Office of Child Support Enforcement Services.

With our mobile population, interstate child support cases are also increasing. Seventeen percent of the collection caseload in Louisiana is in this category, but there are no teeth in the interstate enforcement. We are wasting time to file non-compliance complaints in federal district court.

Federal officials tell us to work on welfare cases. With the resources available to us, we must establish priorities. Unfortunately, the non-revenue producing elements—the non-welfare cases, paternity establishments and interstate cases—go down on the priority list, while we concentrate on that which will bring us the dollars to keep the program going.

Louisiana is making great strides toward a more effective enforcement system.

The automated data processing system has been reporgrammed, made reliable and useable for both workers and managers.

Long range investments have been made in more staff and better training.

A mandatory wage assignment law was passed in 1982.

A proposed state tax offset bill has passed the House of Representatives and is now pending in the State Senate.

These changes are not the result of anything the federal government did.

We believe that many other states are also finding ways to provide more services more efficiently. Restructuring a stable program just when we are making headway will have a devastating effect on those efforts. We need to build on what we have instead of starting all over.

Some administrative changes are being proposed in Congress this year to make the program more effective. We would urge that those changes be given a chance to work before tampering with the funding formula.

There are many variable factors which determine the effectiveness of the Child Support Enforcement Program within an individual state. Among these are its state laws, support enforcement history, its organization, staffing, enforcement procedures and unemployment statistics. We recommend that Regional Offices of the Office of Child Support Enforcement and the Institute of Child Support Enforcement work with individual states in pinpointing problems and seeking solutions.

There is no question that child support enforcement is even more a national issue now than in 1975. Unless IV-D is truly a national program, it can never accomplish its purpose. Restructuring the funding formula without regard to the long range implications will drastically affect the quality of life for a huge segment of society who deserves better. The corresponding rise in crime and in loss of economic productivity, due to poor education, will cost taxpayors far more to combat than preventative measures to ensure child support at the early stages.

You in Congress must determine the future of child support enforcement. Is this to be a program serving all those who need services or is it to be a cost reducing program serving only welfare recipients?

I appreciate allowing me to testify. Be assured that we in Louisiana want to continue working with you for better performance in child support enforcement.

## Statement of Debi Evans, President, Oklahomans Organized for Child Support Enforcement

As a single mother of two, "no" has become an important work in my vocabulary. Its usage has grown tremendously in the past three years, no has become my polite way of telling my children that I can't afford it. You see, I can't afford a trip to the amusement park, or a visit to the neighborhood pool. We are living one day at a time on bare necessities, keeping one step ahead of bill collectors and utility shutoffs. We are surviving on $480.00 per month in unemployment benefits barely above proverty levels, while their father is in arrears over $5,000 in his child support payments.

I am here today, not to ask for charity or sympathy. I am here representing nearly 200 members of Oklahomas Organized for the Enforcement of Child Support, who are all having the same problem: unenforceable child support judgements, because of the lack of concern and follow-up on said orders. We are neither money hungry, nor extravagant; we are loving parents trying to provide for our children and give them the life they deserve. These children are being deprived and suffering needlessly as a result of their lack of child support.

The present statutes were enacted to decrease the AFDC deficit. The system has been somewhat effective in enforcing child support obligations, but the number of delinquent obligations continues to grow. The increased mobility of the individual in today's society has made it nearly impossible to locate an absent parent. In our efforts to locate these delinquent, absent parents we have used every method at our disposal, both ethical and not so ethical. We have been taught by the experts how easy it is to avoid court orders.

Parental responsibility has become an option rather than a responsibility for many absent parents. The custodial parent has become a warehouse for the remnants of the relationship, while the other merely changes suppliers. There are methods of stopping this in business, aren's our children of at least equal importance?

At present, we are aware of at least five kindergarten aged children that are left unsupervised daily, due to lack of funds in the household available for child care. This is a sad commentary on the American System, when a mother must sacrifice the child's safety for its survival. Sometimes we question whether or not we are guilty of false pride; a woman is often faced with one of two unpleasant options at the time of divorce: she may either return to work, or apply for public assistance. A formerly self-sufficient woman who, after experiencing the trauma of divorce, is now unable to provide for her children quite often feels dehumanized or a worthless failure. On the other side of the coin, a great number of mothers had wished to make child rearing and homemaking their career; because of their lack of marketable skills, they are quite often faced with a situation more tenuous than the welfare recipient. Which of these two choices would you make?

As head of a single parent household, I have found utility companies and landlords less patient than I have been in waiting for the children's support. Although the court has ordered the children's medical insurance to be provided by their father, I have become responsible. Collection personnel realize that child support is an unrealiable source of income and refuse to wait for payment. I have been patient, understanding, and have done my best to provide for my children. My patience has run out as a result of seeing my children suffer for the irresponsibility of their father.

At the time of conception these children had two parents sharing the miracle of life, but the current quality of this life is at issue. They are being deprived due to unresolved conflicts between two self-sufficient adults. They are being punished for the divorce of their parents. Child support enforcement is the right of every child who has been victimized by the dissolution of his/her biological family.

Senator DURENBERGER. Senator Long?

Senator LONG. Let me say to both of vou that I just cannot believe that this recommendation is understood by the President in whose name it is made. This sounds to me like one of those cases where people in the bureaucracy find ways of frustrating what their own boss, the Chief Executive, would like to see done.

It was my privilege to work for years with Mr. Robert Carlson, who is down there in the White House as an adviser to the President in the welfare area. Mr. Carlson once served over in the Department of HEW, and he told me that when he was over there the long time bureaucrats would always say, "Well, if you want to economize, I'll tell you one way to economize: Get rid of the child support enforcement program," because the people over there had no sympathy with making a father pay anything. They wanted to play Santa Claus. The very idea that they would have to go out and make some father pay to support those children was completely repugnant to their whole philosophy. Their idea was that the government ought to pay for all of that, that you shouldn't ask any father to pay to support those children, that that's what welfare is for, so fathers wouldn't have to support their children.

Fortunately, I know that Mr. Carlson would not support that view, and I am going to discuss it with him. I doubt very much that he ever advised that down there in the White House.

I have no doubt whatever, from hearing the President testify before this committee and from discussing it with him personally, that Ronald Reagan strongly supports the most effective child support program that can be put together. And the very idea of coming in with something that could kill the whole program to me is just incredible, and I don't believe the President understands this. I don't think he has been even informed about it. And I'll bet you he hasn't been told what the State administrators of the IV-D program think about it.

Ms. HUNTER. We wish we could do so.

Mr. BARBER. Senator, there is a point and an example that comes to mind. You know how long it took us—and this is not only as a deputy district attorney but also through the American Bar Association—to get funding on the nonwelfare side. You are a strong proponent of that, and you clearly saw that by getting adequate funding on that side we could keep people off of aid and save IV-A costs, just costs of running those cases.

Where did the opposition come from to that? It came from the Reagan bureaucracy, really—didn't it?

Senator LONG. Well, I'm satisfied that there has always been a group down at the Department who would like to get rid of all child support enforcement. They have no sympathy for any program to either make somebody work or to make the father pay to help support those children. They want to play Santa Claus, to go around and be the popular people, giving away money at the taxpayers' expense, money that need not be given away.

But for the benefit of those children as well as just in justice for taxpayers, we have got no business paying ou the taxpayers money to support children where the father is fully capable of supporting those children, and where most honorable, decent fellows would be supporting their own children. Now, we've got no business making the taxpayers pay for all of that.

I hope that you will take a message back to Mr. Mamoulides, Ms. Hunter. He is a very effective and outstanding district attorney, one of the most outstanding in the country. I wish you would take the word back to him that he should contact the other district attorneys and have them contact their Senators. He can do that job himself as far as Louisiana is concerned—he is that kind of a district attorney. If you've got John Mamoulides against you in Jefferson Parish, you are going to lose lots of votes down there, just lots of votes. It will cost you votes by the thousands.

But he has influenced other district attorneys, and I wish you would tell him that they ought to express themselves, particularly the outstanding ones such as Mamoulides. They ought to express themselves to their Senators and their Representatives just as he has done, because if they will do it I think they will see that the program will continue. The program needs to be more effective, because this is one of the areas where we have the real potential—putting people to work and requiring fathers to support their children are two of the areas where we have the greatest potential. And I would say everybody is for it except those runaway fathers.

Thank you.

Ms. HUNTER. Thank you.

Senator LONG. I would like to put in the record in support of what has been said here an editorial out of the Washington Post.

The CHAIRMAN. An editorial about Dads and Father's Day. It was in today's Post.

[The editorial from the Washington Post follows:]

[Editorial from the Washington Post, June 16, 1983]

### DEADBEAT DADS

Sunday is Father's Day, and most American children will be doing something special for dear old dad. It's a useful occasion for children to remember that the old man works hard to keep a roof over their heads and that, for all his faults, he's not such a bad fellow to have around the house. But Father's Day will be only an unhappy reminder for millions of children that their fathers no longer care enough about them even to help pay for their upbringing.

The failure of fathers to contribute to support of their children is no longer a problem confined to a substrata of American families. More than 8 million families now lack a male parent, and with 1.2 million new divorces every year, the number continues to grow. Experts estimate that one-half of American children—from all income levels—will live apart from their fathers for part of their childhood. For the great majority of them, the departure of the father will mean a steep and often permanent drop in their living standards.

Fewer than three of every 10 fatherless families receive regular child support payments from the absent father, and the payments received average less than $2,500 a year. Even when fathers are under court order, less than half pay regularly, and perhaps as many as a third never make a singly payment. Contrary to popular belief, many of these delinquent fathers have substantial incomes. A California study showed, moreover, that a year after divorce, while the wife's income typically dropped by 73 percent, the husband's rose by 42 percent.

For most women, pursuing a recalcitrant ex-mate is a bleak and expensive process. Courts have huge backlogs of child-support cases, and even if a judgment is won and arrears are collected the victory is usually temporary. It is especially easy for fathers to avoid further payments by moving to a different state or, in some cases, even a different county.

In recent years the federal government's child support enforcement program has helped states crack down on absent fathers whose families have been forced onto welfare rolls. The program has already produced significant welfare saving in many states, and the Reagan administration is preparing legislation to strengthen provision of withholding wages and tax refunds from delinquent parents and helping states coordinate collection efforts. These are sensible proposals. But they do little to help either the families involved—since collection simply offset the typically low welfare benefits—or the equally large numbers of deserted families that have avoided welfare but still scrape by on relatively meager incomes.

As more and more families have become exposed to the weakness and the child-support system, Congress has become increasingly interested in additional measures that would have broader impact. Child support is one issue that appeals—rightly—to all parts of the political spectrum. A prospective welfare saving is only one small part of that concern. A society that cares about its future will make every effort to see that its children are not raised in deprivation and that their parents recognize that the decision to have children entails lifelong responsibilities.

Senator LONG. I am pleased to say that the chairman of our committee, Mr. Dole, has supported this effort to try to make those fathers make a contribution to the support of their children.

The CHAIRMAN. Thank you.

I have no questions. And I want to thank Senator Long and others. We have been trying to mark up a farm bill all morning, and that's not easy to do, either.

Thank you very much.

Our final panel will be Peter Smith, Richard Nelson, James Budde. Did I pronounce it right? Oh, there isn't any James Budde.

Dr. NELSON. Mr. Chairman, I believe there are only tow of us.

The CHAIRMAN. Only two? Who is missing?

Dr. SMITH. I am Smith.

Dr. NELSON. And I am Nelson.

The CHAIRMAN. All right. Go ahead.

## STATEMENT OF DR. PETER S. SMITH, DIRECTOR, HEMOPHILIA CENTER OF RHODE ISLAND, PROVIDENCE, R.I.

Dr. SMITH. Mr. Chairman, I would like to take the opportunity to thank you for the opportunity to explain why I and the people I represent, hemophiliacs in the community and treaters of hemophiliacs, are against the elimination of the 15 percent set-aside from the appropriation for the Maternal and Child Health Block Grant.

I am Dr. Peter S. Smith. I am assistant professor of Pediatrics at Brown University, and I am codirector of the Hemophilia Center of Rhode Island.

We are part of a regional network of hemophilia centers which provide the most modern kind of care to hemophiliacs. This effort has been cost-saving and also saving in suffering and disability. We are most grateful for the support that the Federal Government has provided over the years for much-needed hemophilia research and care. This support has truly revolutionized treatment over the last 10 years. Patients, formerly housebound and unable to work because of bleeding into their joints and crippling, are now contributing to the goals of our society—going to school and working. This is because plasma concentrates have become widely available and home infusion therapy has freed them from hospital care and

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emergency room visits. There is no better example of the rapid translation of scientific advances into patient care.

The Federal and State support of comprehensive care centers throughout the country has provided an essential mechanism for the dissemination of these scientific advances.

Let me go back a bit on the history of the comprehensive centers. In 1975 Congress established the comprehensive hemophilia diagnostic and treatment center program, Public Law 94, and appropriated $3 million to establish 22 regional hemophilia centers with 60 affiliates. This network of centers has expanded and now offers comprehensive care. They provide multidisciplinary diagnostic and treatment services, including psychosocial, financial, and vocational counseling, in addition to the medical and dental and orthopedic care that we have always been providing.

The impact of these programs has been very dramatic. Between 1975 and 1981 the number of patients who have had access to this type of care has more than tripled, and two-thirds of them are now capable of treating themselves with appropriate blood products. The number of days that they spend in hospital per year has been reduced from nine to approximately 2. The number of days lost from work and from school each year because of bleeding has decreased fourfold. Unemployment has decreased from 36 percent befor funding to 13 percent, and is as low as 4.5 percent in the New England States.

The number of patients with third-party coverage has increased from 74 to 93 percent, and the out-of-pocket expenses, those associated without direct medical care, has decreased from $850 to $340 per year. In my State there is no out-of-pocket expense.

These benefits have been accomplished by a program that also led to significant economic savings. Studies have documented a 62-percent reduction in total health care costs per patient. This represents an annual savings of $93.7 million, a savings that was achieved by an investment of $2.6 million during fiscal year 1983.

There is no mystery why these savings are realized. Comprehensive care prevents the complications of hemophilia.

Let me discuss the relationship of this program to the 15 percent set-aside of the maternal and child health block grant. This set-aside was provided to take care of programs of regional and national significance, because hemophilia is a disease of low prevalence. Many of the States do not have resources, the expertise, and the moneys to be able to support an infrastructure of this kind.

We feel that the 15 percent set-aside should be maintained. Indeed, we would like to see that amount increased, so that the 10,000-odd patients with hemophilia who are yet unserved in the country can be served by this approach, and that the attendant savings can be realized.

We would also like to submit to you a recommendation for increase in the authorization from $373,000 to $483,000 to allow us to fulfill these goals.

Finally let me mention one spectre which we have recently seen appear in hemophilia, and that is AIDS. As you realize, blood products carry with them the chance of transmitting AIDS to patients which is lethal in 50 percent of the cases. We need the support to help care for this disease. We need the support for the research to prevent it from occurring and to detect it before it actually has occurred.

I would like to thank you for the time you allowed me to speak to you on these concerns.

The CHAIRMAN. Thank you very much, Dr. Smith.

Dr. Nelson?

[Dr. Smith's prepared statement follows:]

### STATEMENT OF THE DIRECTORS OF HEMOPHILIA CENTERS AND THE NATIONAL HEMOPHILIA FOUNDATION, PRESENTED BY PETER S. SMITH, M.D.

I am Dr. Peter S. Smith. I am Assistant Professor of Pediatrics at Brown University and Medical Co-Director of the Hemophilia Center of Rhode Island. I am speaking to you today on behalf of the Directors of Hemophilia Centers and of the National Hemophilia Foundation. The Hemophilia Center of Rhode Island is part of the regional network of New England states associated with the federally-funded New England Area Comprehensive Hemophilia center.

We are most grateful for the support that the Federal Government has provided over the years for much-needed hemophilia research and care. This support has truly revolutionized treatment over the last ten years. Patients formerly housebound and unable to work or attend school because of painful bleeding and crippling are now fully functional and contributing to the goals of our society. This is because plasma-clotting factor concentrates have become widely available and home infusion therapy has freed them from hospital care and emergency room visits. There is no better example of the rapid translation of scientific advances into patient care. The federal and state support of comprehensive care centers throughout the country has provided an essential mechanism for the dissemination of these scientific advances.

#### COMPREHENSIVE CENTERS

In 1975, Congress established the Comprehensive Hemophilia Diagnostic and Treatment Center Program (Section 1131 of P.L. 94-63) and appropriated three million dollars to establish twenty-two regional hemophilia centers with sixty affiliates. This network of centers has expanded and now offers comprehensive care to over 9,500 hemophiliacs, approximately half of the total hemophilia population in the country. They provide mulidisciplinary diagnostic and treatment services including psychosocial, financial and vocational counselling, in addition to medical, dental and orthopedic care. The impact of these programs has been dramatic. Between 1975 and 1981:

The number of patients served by the centers has more than tripled and two-thirds of them can treat themselves when needed.

The number of days spent in the hospital per year has been reduced from 9.4 to 1.8.

The number of days lost to work or school each year because of bleeding has decreased four-fold.

Unemployment has decreased from 36 percent before funding to 13 percent (and as low as 4.5 percent in New England).

The number of patients with third-party coverage has increased from 74 to 93 percent.

And, the out-of-pocket expenses per patient per year have decreased from $850.00 to $340.00 per year (In Rhode Island there are no out-of-pocket expenses).

These benefits have been accomplished by a program that has also led to significant economic savings. Studies have documented a 62 percent reduction in total health care costs per patient ($15,800 per year in 1975 to $5,932 in 1981). This represents an annual savings of 93.7 million dollars, a savings that was achieved by a program that cost the federal government 2.6 million dollars during fiscal year 1983. There is no mystery why these savings are realized—comprehensive care prevents complication of hemophilia that require costly hospital services. Comprehensive care also prepares patients for home therapy so they do not need 25 to 40 hospital visits each year for bleeding episodes. However, federal support has made comprehensive care possible for just one-half of the hemophiliacs in this country. I urge you to consider the additional savings and human benefits that may be realized if increased funding permits comprehensive care programs for the currently unserved hemophiliacs.

## RELATION OF COMPREHENSIVE HEMOPHILIA CARE TO THE MATERNAL AND CHILD HEALTH BLOCK GRANT

Two years ago hemophilia treatment center funding was included in the Maternal and Child Health Block Grant as part of the special 15 percent set-aside of appropriated funds. At that time the funding level was 3.3 million dollars. It was reduced to 2.6 million, a 21 percent decrease despite a tripling of the number of patients served by the centers. Even though a major effort is being made to do more with less money through regionalization, there are still twenty-five states that are not covered by federally supported programs.

In many instances, as in Rhode Island, the state is contributing significantly for the support of hemophilia programs. Unfortunately, however, there has been a recent disturbing trend that has placed many other state-funded hemophilia programs in jeopardy. At this difficult time, it is not realistic to expect new or expanded state funding of these programs. Maintaining the 15 percent set-aside of the Maternal and Child Health Block Grant appropriation is consequently essential to the survival and expansion of comprehensive hemophilia care in this country.

## AIDS AND ITS RELATION TO HEMOPHILIA TREATMENT CENTERS

Acquired immune deficiency syndrome is a serious disease which has been highly publicized in the media. As of May, 1983, 1,450 cases have been confirmed by the Center for Disease Control and the number has doubled about every six months. Nearly 40 percent afflicted with this disease die and it is estimated that the number will double since there is no effective therapy and the course tends to be protracted. Fifteen hemophiliacs have developed AIDS and nine have died, and virtually all hemophiliacs are vulnerable because of their dependency on blood products. Since AIDS appears to be transmitted through blood derivatives, there has been a profound psychological effect of this threat on hemophiliacs and their families. The source of their newly-found freedom from pain and disability has changed overnight to possibly endanger their very survival. In this setting comprehensive care with its psychosocial support is even more essential. Physicians and nurses are seeing patients much more frequently because what was formerly passed off as trivial problems is viewed as a possible harbinger of AIDS, a fatal disease that has been diagnosed in nearly one of every 1,000 hemophiliacs. Thus we have a special interest in efforts to understand and control AIDS. We consider research in this area to be a matter of highest priority and we urge you to give this problem your most serious consideration.

## APPROPRIATIONS REQUEST

### *1. Fiscal year 1984 appropriations for treatment centers*

We urge you to appropriate—as a line item—$4.6 million for fiscal year 1984 to support the hemophilia Treatment Center Program. If we are to adequately address the needs of hemophiliacs yet unserved by the regionalized network established by the Office of Maternal and Child Health, this increase is essential. Treatment centers must respond to the real medical threat of AIDS and this requires funding support.

### *2. Set-aside*

We request that you retain the 10 percent level for a set-aside within the Maternal and Child Health appropriations. The set-aside was established for a very good reason. It is more efficient to distribute resources for special programs of regional and national significance on a regional and national basis rather than through block grants to states. This innovative approach has made the Hemophilia Treatment Center Program a model for other chronic diseases.

### *3. Maternal and child health funding*

We urge that you fund MCH at the full authorization level. It is an investment in the future of our country.

### *4. Research*

As long as hemophiliacs depend upon products derived from human blood, they will be vulnerable to any contamination. Research to eliminate these contaminants and to develop alternative treatment methods is an urgent need. Resistance to clotting factor develops in 10 percent of hemophilia patients seriously compromising care. Basic biomedical research supported by the National Institutes of Health and the National Heart, Lung and Blood Institute is therefore a vital concern to us. The

Centers for Disease Control need increased funding so that they can expand laboratory investigation and epidemiologic studies concerning AIDS and detection of individuals at high risk of AIDS transmission.

### SUMMARY

In short, significant strides have been made in medical, psychosocial and socioeconomic terms since the establishment of the federally-funded comprehensive hemophilia program. Although access to such programs has been possible for half of our country's hemophiliacs, extending these benefits to the rest will be impossible without increased funding.

Something new now threatens the gains that have been obtained through joint efforts over the past decade. AIDS is a cloud over the hemophilia community. We need your help to respond to this new and potentially devastating problem.

## Hemophilia Treatment and Research Appropriations Fact Sheet

### APPROPRIATIONS NEEDS

$4.6 million for fiscal year 1984 to support hemophilia treatment center program for maintaining comprehensive care and expansion needed to meet the increased demand for services due to AIDS;

Retaining the 15 percent set/aside and MCH funding at the full authorization level; and

Full funding for basic biomedical research.

### *I. Hemophilia—What it is?*

Hemophilia is a lifelong, hereditary blood clotting disorder which affects males almost exclusively. Hemophiliacs' blood does not clot due to the inactivity of a plasma protein in their blood. Hemophiliacs may experience uncontrolled, painful bleeding and hemorrhaging. Chronic joint bleeding results in progressive joint damage and crippling without adequate treatment.

### *II. Hemophilia treatment center program*

A. Background: In 1976, the Congress first appropriated funds for comprehensive hemophilia diagnostic and treatment centers. Since then, support for this categorial program was included in Maternal and Child Health (MCH) funding, not as part of the block grants, but as part of the 15 percent set aside within MCH appropriations. This was done because: it is more efficient to distribute resources for hemophilia on a regional and national basis; and the hemophilia treatment center program is clearly a special program of regional and national significance and is a model for other chronic diseases.

B. Regionalization: There are now ten regional hemophilia treatment center programs with over 75 centers and affiliates. All of the ten funded programs serve more than one state's population. Because the program serves a low density scattered population, it cannot be administered in a state-by-state way without seriously compromising current efficiencies of scale.

C. Program Impact: Since 1975, the impact of these programs has been dramatic:

The number of patients seen at both primary treatment and affiliate center sites increased more than 225 percent;

The number of patients in these regions receiving comprehensive care and the number on home care has nearly quadrupled;

This has led to substantial reduction in need for hospitalization so that the average number of hospital days per year per patient has been reduced by 80 percent; from 9.4 to 1.8;

Moreover, there has been a 75 percent reduction in the number of days lost from work or school each year; and

In these difficult times, the percent of unemployed adults dropped from 36 percent to 12.8 percent overall—and is as low as 4.5 percent in some regions (e.g., New England States).

With comprehensive care, disability, unemployment and medical costs have been substantially reduced thus enabling hemophiliacs to live nearly normal and independent lives.

D. Fiscal Impact: Total health care costs have been reduced by 62 percent—an annual savings of $93.7 million. These savings are realized only from those who are enrolled in federal treatment programs (less than one-half of the nation's hemophiliacs).

E. Acquired Immune Deficiency Syndrome (AIDS): Because of the hemophiliacs' dependence on blood products, they have become vulnerable to AIDS. As a result, the need for comprehensive care is greater than ever before.

F. International Model: The United States comprehensive care approach and patient education methods have become an international model that is being promoted by the World Federation of Hemophilia. The model is now being published in four different languages and is being distributed throughout the world.

*III. Research, hemophilia, and AIDS*

Because hemophiliacs depend upon a factor derived from blood plasma, they are vulnerable to anything that may contaminate blood products. More research and epidemiologic work needs to be done to reduce the spread of AIDS and, in the long run, to reduce other risks of blood infectivity in the future. Such research will benefit the general public as well as hemophiliacs.

## STATEMENT OF DR. RICHARD P. NELSON, GILLETTE CHILDREN'S HOSPITAL, ST. PAUL, MINN.

The CHAIRMAN. I might say, as I assume has already been said, that your entire statements will be made a part of the record.

Mr. NELSON. I am just going to read a few selected comments from my written statement.

I am Richard Nelson. I am a pediatrician and the medical consultant to the crippled childrens program in Minnesota, and I am here representing the association of programs that administer maternal and child health block grants in the States.

We do not support the Administration's recommendations to amend the maternal and child health services block grant, title V, should not be adopted by Congress.

The enactment of the block grant legislation 2 years ago and the accompanying reduction in funds available under title V have produced many changes in State programs. Adjustments are still being made. Further changes in the programs through change in the legislation might result in significant dislocation of services to mothers and children The States have not yet had sufficient experience with the block grant legislation, and full and accurate assessment of its current aspect as written is not fully known.

In fact, we believe that the funding cuts of last year have obscured in many ways the impact of many of the specific provisions of the legislation.

The most pressing problem facing many State maternal and child health and crippled children's programs is the inadequacy of funds available to these programs. As you are aware, in 1982 title V was reduced by approximately 20 percent. At this time we are seeing nationwide serious issues in the adequacy of prenatal care to low-income women, maintenance of preventive services that we feel are necessary to prevent long-term disability and high-cost health care, and also increasing evidence of inadequate care for handicapped children from low-income families.

The administration has proposed several changes in title V, in the health services block grant, and I simply want to make a couple of comments about several of them.

The first has to do with the elimination of the so-called "set-aside" for projects of regional and national significance. We are in agreement with Dr. Smith and other organizations representing programs that receive funding under the set-aside. We do not feel that any change in the formula that establishes the current set-aside is appropriate at this time.

These funds provide many targeted approaches to low incidence problems, and there simply is no other basis for any national Federal maternal and child health effort without the Department of Health and Human Services having these funds to support a variety of projects.

We also oppose the elimination of the State maintenance of effort as part of the block grants. The maintenance of effort is the visible evidence of the partnership of the Federal and State governments in these programs. We do not feel that the elimination of the maintenance of effort will have a positive impact; because in those States that have currently difficult budget crises, maternal and child health programs typically do not have the kind of constituency that competes well with other demands for State budgets. And in fact there is some evidence under the provisions of the emergency jobs bill that, when States did receive a supplemental appropriation under maternal and child health, there was great pressure in the States to use those Federal dollars instead of State dollars. Obviously that was prohibited in the legislation, but that question was raised.

Several additional comments:

We feel that a single administrative agency at the State level should be responsible for planning and programmatic coordination of maternal and child health services, and the block grant funds would not be used accountably if there is no focus.

In summary, we do feel that in the climate of current State difficulties with budgets as well as in many States' organization of human services that further change in the block grant would not be productive and would result in a dimunition of services to low-income mothers and children.

We need greater time to study the impact of the current block grant. We understand there will be a report this fall from GAO on implementation of the block qrant, and it would not serve well the interests of the constituency receiving these funds to have changes made at this time.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Richard P. Nelson, M.D. follows:]

### STATEMENT OF RICHARD P. NELSON, M.D., ASSOCIATION FOR MATERNAL AND CHILD HEALTH AND CRIPPLES CHILDREN'S PROGRAMS

It is the position of the Association for Maternal and Child Health and Crippled Children's Services Programs that there should not be any substantive amendments to the Maternal and Child Health block grant legislation (Title V of the Social Security Act) at the present time. The enactment of the Maternal and Child Health block grant legislation less than two years ago, and the accompanying substantial reduction in fedeal funding for Maternal and Child Health block grant programs have produced significant changes in these programs in many states to which adjustments are still being made. Further changes in these programs which would result from new amendments to the Maternal and Child Health Services Block Grant legislation might well create significant dislocation in the administration and operation of the state MCH and CC programs. Furthermore, states have not had, as yet, sufficient experience with the MCH block grant legislation to allow a full and accurate assessment of its impact. It should be noted that the association is cooperating with the National Maternal and Child Health Resource Center which is collecting data about the impact of the block grant legislation.

The most pressing problem currently facing the state MCH and CC programs is the inadequacy of funding being provided to these programs. As you are all aware, federal funding for MCH block grant programs was reduced in 1982 by approximately 20 percent. Even at the 1981 appropriations level these programs were not funded sufficiently to enable them to fulfill their mandate of providing needed health services to mothers and children, including handicapped children. While the supplemental appropriation for the MCH block grant in the emergency jobs bill has provided some assistance to these programs in order to enable them to increase their provision of services, there is a demand for services which they still cannot meet. Moreover, the cost of providing services has increased tremendously due to inflation in health care costs. For example, in Minnesota MCH-funded health services for a child with the birth defect, cleft palate, rose from an average of $1,006 in fiscal year 1981 to, $1598 the following year, an increase of 59 percent. Similar increases have been encountered in the treatment of children with cerebral palsy, hearing the loss and other disorders.

The administration has proposed several pages of Title V (Maternal and Child Health Services Block Grant) to which we offer the following commentary.

1. Elimination of the Federal "set-aside" for project of regional and national significance, research, and training.

We do not recommend any change in the formula that establishes the current set-aside. Many projects funded with these monies suffered substantial cuts in 1982 that have compromised a variety of health care services. The federal government must maintain the capability to demonstrate that new methods of maternal and child health services delivery can provide improved care as well as integrate fragmented services. In the past set-aside funds have permitted innovative approaches to problem solving, which eventually have changed the service system. An example is the screening of newborn infants for metabolic diseases. Most States now have such programs under law or rule. Other maternal and child health activities are better provided on a regional basis. Care for individuals with hemophilia may sometimes be best accomplished across state borders to provide access to highly qualified care.

There is a continuing need for the training of professionals in Maternal and Child Health. Other services to handicapped children are so specialized and of such low incidence that without supplemental federal grants the quality of care to these individuals would diminish. At the present time the "set-aside" is the nucleus of a national Maternal and Child Health Program and it should not be compromised.

2. Elimination of the requirement of state maintenance of effort.

The MCH program is a partnership of federal and state efforts and the maintenance of effort requirement is a visible evidence of that partnership. Following implementation of the Block Grant some states have been very generous in continuing support for their Maternal and Child Health programs. For such states the activities supported by these programs are the priority. In other states however continuing budget crisis has resulted in static or reduced funding for these programs. We oppose elimination of the match because there would be an unknown impact in states with troubled budgets to meet the health care needs of low income mothers and children. Also, preventive health care services might incur further cuts.

3. Elimination of the prohibition of transfer of funds from the MCH services block grant to other block grants.

For similar reasons we oppose elimination of the no-transfer provision. We are concerned that the MCH block grant allocation in some states would become vulnerable in a contest with other more politically powerful interests.

4. Elimination of the prohibition of states to use research and training monies in providing grants to for-profit agencies or organizations.

We oppose this amendment due to our conviction that in a time of constricted public resources, with underfunding of many public and non-profit programs, diversion of funds would dilute the current efforts of public and non-profit agencies that have experience and expertise with these programs.

5. Elimination of the requirement for states to document planning efforts and report about maternal and child health services.

We feel that the present legislation imposes minimal requirements on the states and that from our information there is no burden.

6. Elimination of the requirement that a specific agency (usually state health agency) is necessary for administration of the block grant.

We oppose this amendment since without a single administrative focus at a state level there would be erosion of planning and programmatic coordination of maternal and child health services. The use of block grant funds will be most accountable if a single agency is responsible for their utilization. Generally the state health agency has the greatest knowledge of systems of care and has the potential to interact with a wide variety of providers in the voluntary and private sectors.

7. Elimination of certain state assurances.

We feel that the current legislation poses minimum requirements on states.

In summary we oppose amendments to Maternal and Child Health Care Services Block Grant. Title V of the Social Security Act is designed to provide targeted funds to States for meeting the health care needs of mothers and children, including handicapped children. Without these funds our states would have no congressionally designated special resource to meet the needs of persons who do not qualify for other federal or public programs such as Medical Assistance. In the current climate of state budget difficulties the resources for this population is subject to extraordinary pressures from powerful constituencies. We might well lose the current capabilities to work with an underserved population if there is any further dilution of the Federal role. We must maintain the Federal leadership role in maternal and child health services.

Therefore it is vitally important that the authorizatioin level of the Maternal and Child Health Block Grant be raised, that the maintenance of effort requirement in the block grant legislation be retained, and the the prohibition against transfer of block grant formula funds to other block grants at the state level be retained in order to insure that these programs will have adequate resources to provide needed health services to mothers and children, including handicapped children.

The **Chairman**. It may be that we will want to submit some questions in writing—not a great number. But if that is satisfactory to each witness, we might want to ask some questions.

I have some questions, but because of the lateness of the hour I would rather submit them in writing if that is satisfactory.

Dr. **Nelson**. That's fine.

The **Chairman**. Thank you very much.

I guess my Kansas friend didn't show up, but if he does we will put his statement in the record.

Dr. **Smith**. All right.

Dr. **Nelson**. Thank you.

[The questions follow:]

[The prepared statement of Mr. James Budde follows:]

[Whereupon, at 12:58 p.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

### TESTIMONY OF JAMES F. BUDDE, ED. D., ASSOCIATE DIRECTOR, KANSAS UNIVERSITY AFFILIATED FACILITY, PAST PRESIDENT/CHAIRMAN, LEGISLATIVE AFFAIRS COMMITTEE, AMERICAN ASSOCIATION OF UNIVERSITY AFFILIATED PROGRAMS FOR THE DEVELOPMENTALLY DISABLED

#### INTRODUCTION

Mr. Chairman, in my capacity as chairman of the Legislative Affairs Committee, I am submitting testimony on behalf of the American Association of University Affiliated Programs for the Developmentally Disabled (AAUAP). I have also served as President of AAUAP (1981-1982), and I currently serve as Associate Director of the Kansas University Affiliated Facility Central Office, Bureau of Child Research, University of Kansas, Lawrence, Kansas.

Mr. Chairman, the following suggestions, made by the Administration, for changes in the Maternal and Child Health Block Grant would not be in the public interest:

1. Elimination of requirement for state matching funds.
2. Elimination of the federal setaside of 10 to 15 percent.
3. Repeal of prohibition against using for profit entities for training and research.
4. Lack of specificity in Congressional language on setaside programs.

#### *1. Elimination of Requirement for State Matching Funds*

In the spectrum of partnership between federal, state, and local governments and the private sector, the Maternal and Child Health Block Grant represents federal leadership of two types, both of which badly need preservation and, in fact, strengthening. First, as voluminous testimony and data documented during the Finance Committee's hearings which preceded the enactment of the Maternal and Child Health Block Grant, adequate maternal and child health represents a vital national interest which transcends state, local, and private interests. According to an Inspector General's report, mental retardation currently costs the federal government over 11 billion dollars per year in payments for support and services to this group. The cost of this enormous expenditure is roughly evenly split between federal and state. A fiscal cost of the magnitude of 5.5 billion dollars defines a strong federal interest. Data reported during previous Senate Finance Committee hearings documented the existence of uneven and inadequate state efforts and, indeed, reported that infant mortality rates in the United States lagged behind those of other countries, further evincing inadequacies of state, local, and private efforts in the area of maternal and child health.

The problems in the states were judged to be ones of priorities and service delivery system structuring. In general, and particularly in times of economic rescession, states do their best to respond to the immediate needs of their citizens. In such cases, the prevention of future problems, a major purpose of maternal and child health, is often shortchanged due to the pressure of immediate problems. In general, higher levels of government have longer range perspectives and can deal more effectively with long-range issues such as prevention.

The fact that achievement of optimal effectiveness is basically a national leadership issue and not a financial issue is dramatized by considering that, all along, increased and effective state expenditure in maternal and child health on the order of magnitude of hundreds of thousands by each state would have saved millions of dollars by preventing mental retardation.

Instead, the issue is one of federal leadership. The federal government needs to continue to motivate states to increase their commitment to maternal and child health. But without the state matching requirement, this basic purpose of the Block Grant would be foiled. States already lagging behind in maternal and child health would be able to reduce maternal and child health programs without the requirement for matching.

The public interest, including the long-range reduction in federal expenditures, points in the reverse direction. The requirement for state match should be increased, and increased federal funding (pulling along further state effort) would allow for the prevention of a significant portion of ongoing federal expenditures for individuals with handicapping conditions.

Note that my recommendations, and not those of the Administration, are consistent with economic public policy in the area of public investment in federal, state, and local programs. Economic theory calls for each level of government to invest in public programs in proportion to the economic interest held by that level of government. The strong federal interest defined by humanitarian and fiscal concern for individuals with mental retardation (5.5 billion dollars per year) justifies a federal effort of far more than the current fiscal year 1983 level of 483 million dollars. Thus, both sound economic theory and common sense call for the federal government to serve its interests by requiring an equivalent state effort.

### RECOMMENDATIONS

1. Retain Requirement for State Matching Funds
2. Increase Requirement for State Match
3. Increase Authorization Level for MCH Block Grant

### *2. Federal Setaside*

The current MCH Block Grant calls for and allows the second type of federal leadership which is critical to the nation's maternal and child health—technical leadership.

Thanks in large measure to Congressional support of the National Institutes of Health, the scientific understanding of causes, prevention, and treatment of handicapping conditions has and continues to advance rapidly. Such findings, as potentially valuable as they are, go into the scientific literature and stop there, unless picked up by service delivery systems at the state and local levels. Careful studies of the diffusion of scientific findings show that unaided, the length of time between scientific discovery and service application can extend as long as 50 years. In a very basic sense, the role of the MCH setaside is to facilitate making available to states the technical knowledge they need to conduct programs in maternal and child health. Since research findings result from federal sponsorship and are known by the federal sponsoring agencies, federal leadership is the best, indeed the only practical way for this information to be made systematically available to states. It is also necessary that research findings be developed into practical service delivery methods. The federal MCH setaside is precisely aimed at these objectives. Applied research activities allow the development of new service delivery method s based on more basic research discoveries (usually under NIH sponsorship), training programs allow for state leaders to become aware of more cost effective methods, and demonstration funds allow for practical models of new methods to be developed in states.

Ironically, while the U.S. is by far the world's leader in the field of research on the improved prevention and treatment of handicapping conditions, it has been convincingly documented that the U.S. effort to implement research findings lags. This helps explain why other countries, with less active research programs, surpass the U.S. in maternal and child health. Many foreign countries are more effective than we are in implementing new research findings, most of which result from U.S. federal expenditures.

In the field of mental retardation, it is widely known that there is a wide gap between research knowledge and service practices in the states. Such findings have been documented by the GAO, and it has been estimated that the future federal expenditures for mental retardation could be cut by as much as one half if existing scientific knowledge were implemented within states.

Currently funded under the setaside are the UAF programs aimed at reducing the incidence and impact of mental retardation and other handicapping conditions.

UAFs provide interdisciplinary training for physicians and other health professions in implementing maternal and child health services and disseminating new techniques for evaluation, diagnosis and treatment of individuals with mental retardation and other developmental disabilities. UAFs also provide state and regional networks for prevention and service, training an estimated 77,000 professionals and serving 50,600 handicapped individuals in 1979 alone. UAFs provide special support to all major federal programs serving the handicapped, including state Title V agencies and the genetic resource centers established in support of the Genetics Disease Act. It has been estimated that only 18 percent of the mentally retarded children receiving MCH and other federally supported services receive services from properly trained providers. It has been calculated that for every case of severe retardation that is prevented, the total gain to society is almost 990,000 dollars. The GAO report on prevention of mental retardation documented the need for state and regional networks for preventive services for metabolic disorders, prenatal care, chromosome abnormalities, rubella, measles, lead poisoning, RH hemolytic diseases, and adverse early childhood experiences.

Another training program funded under the setaside is the network of Pediatric Pulmonary Centers. Chronic pulmonary disease, including cystic fibrosis, chronic bronchitis and asthma, is by far the largest category of childhood disease in the United States. Chilren's lung diseases are the number two cause of death from disease among youth, yet there remains an inadequate supply of health professionals trained in the care of lung-diseased children. In the course of training professionals, these Centers also provide tertiary-level care to a significant number of children through community outreach programs.

These are but two examples of the many significant setaside programs, all of which have the common goal of strengthening state access to technical knowledge which has been developed through research.

Note that not only is the setaside one of the basic purposes of the Block Grant, it also needs to be administered in a way which gets the maximum return on the federal setaside dollar. To this end, the federal dollar would go further if the setaside were made mandatory and not optional. As the above list indicates, we are talking about major long-term highly technical professional efforts. Frankly, it is hard to attract top professionals to these areas of endeavor. They would rather be doing research or serving in private practice. Constant uncertainty discourages recruitment and retention of the technically qualified leadership needed. The interest groups representing the populations served by the MCH Block Grant all favor the setaside at least at the 15 percent level, and it is wasteful to constantly rehash an issue on which a broad concensus exists.

### RECOMMENDATIONS

1. The federal setaside be retained.
2. The setaside be made mandatory at 15 percent.
3. Serious consideration be given to making more funds available to the programs now funded under the setaside without taking funds away from the state portion of the Block.

### *3. Repeal of Prohibition Against Using Profit Entities for Training and Research*

If the system worked perfectly in communities and states, there would be no need for a Maternal and Child Health Block Grant. But it does not work perfectly, and there exists what economists term market imperfections. The network of University Affiliated Facilities funded under the setaside, for example, is directly concerned with seeing that all institutions of higher education throughout the U.S. know and teach the latest and most effective service methods. The non-profit requirement focuses these funds on universities in such a way that the universities themselves are forced to change. Incentives for change include the requirement for university contribution over and above the grant funded under the setaside. The non-profit requirement also helps assure the long-range federal interest by the charter of the non-profit grantee and the oversight of non-profit interest groups. Profit entities are by nature driven by immediate economic rewards which are short term. By definition, they cannot deal with market imperfections.

#### RECOMMENDATION

Limit training and research to non-profit organizations.

### *4. Lack of Specificity in Congressional Language on Setaside Programs*

The Block Grant consolidated, simplified, and shifted responsibility to states. Principles underlying these changes included: (1) moving programmatic decisions closer to policy officials directly responsible to the public being served and (2) reducing regulations so that responsible officials could administer programs more effectively. We hear that there have been many positive changes at the state level (although we do not have comprehensive information on this) as a result of the Block Grant language.

However, for the setaside portion of the Block Grant, more specific language is needed in a variety of areas. The UAF program is a case in point.

The following principles related to the UAF program should be incorporated in the Congressional language establishing the mandatory setaside:

1. The national network of MCH-supported UAFs be maintained at a minimum of 20, geographically and programmatically focused on national and multistate needs.

2. The UAF network be funded at an adequate level to maintain such a mission. This includes, but is not limited to, establishment of a minimum grant of 500,000 dollars for each of the 20 MCH-supported UAFs and restoration of the overall funding of these UAFs to the fiscal year 1980 level as rapidly as practical and at a rate at least proportional to increases in the setaside. The purpose of this restoration is to restore uniform national coverage of high quality.

3. To extend the impact of the UAF program to states currently not served by the existing 20 MCH-supported UAFs and thus help assure that all children with mental retardation and developmental disabilities in all states are served by adequately trained personnel, new funds should be made available to provide all other UAFs funded under P.L. 88-164 with grants to cover the cost of medical program components of the highest possible quality. A $150,000 minimum shall be established for such grants.

4. More active quality assurance by:

(a) Establishment of formal quality standards (incorporating public comment) for UAFs supported under the MCH Block Grant.

(b) Review of UAFs by an objective peer review process involving site visits.

(c) Providing UAF not in compliance with standards with a written statement of exceptions with a clear specification of appropriate remedial action and a fixed period of 1, 2, or 3 years by which time such remedial action must be completed for each exception.

(d) Defunding of programs not meeting remedial action agreements by end of periods specified.

(e) A formal objective appeal process be established for programs designated for defunding.

(f) Replacement of defunded programs (through an open competitive process) with new programs which do meet standards so that the national UAF network is maintained and national coverage is sustained.

5. UAFs need stable funding, therefore grants should be of a 3, 4, or 5 year duration.

### RECOMMENDATIONS

1. Restore research and training as line item portions of the setaside portion of the MCH Block Grant.
2. Hold hearings on the setaside programs.
3. Enact formal Congressional language specifying guidelines for the national networks of regional resources centers, including UAFs.

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## STATEMENT BY THE AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

The AFL-CIO is pleased to have the opportunity to share its views with the Committee on proposals to reduce funding for essential social programs, such as Medicare, Medicaid, Supplemental Security Income (SSI), Aid to Families with Dependent Children (AFDC) and Child Care programs. Organized labor hopes the Committee will decide these proposals are unfair, ill advised and should not be enacted.

Since the Reagan Administration took office, our country has experienced the highest rates of joblessness since the great depression. At the same time, drastic cuts in social programs have made it harder for unemployed workers, the elderly and the poor to cope with the ravages of the recession.

We hope the Committee, in carrying out its reconciliation instructions for fiscal year 1984, will look long and hard at the effect which recent budget cuts have had on the ability of these programs to cushion the blow of economic devastation resulting from the Reagan recession and look elsewhere for ways of raising federal revenue. For the strength of our country is the sum total of the health and welfare of its people. Further cuts in social programs will only prolong the suffering that is going on throughout the country and hinder any hope of an economic recovery that will benefit every group in our society.

### MEDICARE

According to the agreement of the budget conferees, the Committee is expected to cut $400 million in Medicare expenditures for fiscal year 1984, without any further increases in beneficiary cost sharing. The AFL-CIO has some suggestions on how to achieve that goal but would first like to express its views on the President's fiscal year 1984 Medicare proposals and comment on the cost saving recommendations of the Senate Budget Committee. Even though it is highly unlikely that these recommendations will be enacted this year, the AFL-CIO would like to go on record as being strongly opposed to the Medicare cuts the Reagan Administration has proposed.

On January 1, 1984 the deductible for hospital insurance (Part A of Medicare) will rise from $304 to $350. The premium for medical insurance (Part B of Medicare) will rise from $12.20 per month to $13.50. Earlier this year the Reagan Administration released its proposals to cut the Medicare program by $1.3 billion in fiscal year 1984. If enacted, the new cuts would require Medicare beneficiaries, who now pay a deductible for the first day of care and nothing for the second through the 60th day, to continue to pay the deductible and an additional 8 percent of the deductible per day for the second to the 15th day and 5 percent of the deductible for the 16th through the 60th day. After the 60th day, Medicare would waive all costs.

The Administration attempted to market this proposal by stressing the additional coverage for catastrophic-related expenses. However, the proposal would only cover catastrophic-related expenses incurred in the hospital, and do nothing for high medical expenses incurred outside of the hospital. Only 177,000 of the 29 million Medicare beneficiaries ever stay in the hospital long enough to benefit from the proposed change. Since the average length of a hospital stay for persons over 65 is 11 days, this proposal would require senior citizens to pay $650 out of pocket per hospital stay, which would amount to $300 more than is required under current law and would represent almost two months of benefits for the average widow on social security.

Another proposal advanced by the Administration was to raise monthly premiums paid by beneficiaries for medical services (Part B) from the current level of $12.20, which represents 25 percent of program costs, to 35 percent in 1988. If Congress adopted this proposal and medical costs continued to rise at current rates, the monthly premium would rise to $31.60, or almost three times the amount Medicare beneficiaries now pay. Such a dramatic increase in premiums would force large numbers of beneficiaris to drop Part B and go without physician and laboratory services.

A third proposal suggested by the Administration was a freeze on physician reimbursement. Since Congress has not yet required physicians to accept assignment, i.e. to accept as full payment the fees Medicare determines are fair, as the AFL-CIO has long urged, this provision would only result in fewer physicians accepting assignment and their turning to patients to make up any reductions in reimbursement.

After looking at the effect of the Reagan Administration's budget proposal on Medicare beneficiaries, the Senate rejected one-half of the Administration's proposed reductions. The Senate Budget Committee discarded the idea of imposing additional copayments on Part A services, but did recommend that the Committee consider raising Part B premiums for individuals and families with adjusted gross incomes of $25,000 and $32,000, respectively.

In the opinion of organized labor, the savings that would be associated with implementation of this proposal are totally outweighed by its long-run negative impact on the Medicare program and its beneficiaries. If enacted, this proposal would significantly alter the fundamental premise of the Medicare program that access to medical care is totally independent of one's ability to pay and, depending upon where income levels are set, could be a significant barrier to care now or in the future for many senior citizens.

The other issue that has been discussed, as a means of reducing Medicare expenditures, is the proposal to give Medicare beneficiaries a voucher equivalent to the cash value of Medicare and encourage them to shop around for the insurance policy which meets their needs. Organized labor strongly opposes the voucher proposal. We believe vouchers would lead to the dismantling of the Medicare program, reduced access to health care and higher program costs.

Vouchers will not work, because the medical care system does not respond to the traditional laws of supply and demand. Consumers cannot predict what health care needs they will have in the future. As a result, financial incentives could be used to influence the healthiest beneficiaries to abandon Medicare for less health insurance coverage. Since even the insurance industry has acknowledged that private insurance cannot duplicate Medicare coverage, senior citizens choosing low option plans would be left unprotected against the high cost of getting sick. As for the federal government, its costs would rise because of the additional expense associated with treating the most difficult and expensive cases without the ability to offset higher costs by having beneficiaries in the program who are healthier and less expensive to treat.

Also if, as is predicted, large numbers of beneficiaries opt out of the Medicare program for less expensive private insurance, Medicare will lose any leverage it now has to reduce the rates of increase in hospital costs or monitor the quality of care.

If the Committee wishes to reduce federal expenditures for Medicare by the $400 million in fiscal year 1984 as called for in the budget agreed to by the conferees, the AFL-CIO suggests that the Committee consider the following:

1. Taking steps to reduce the annual rate of increase in physician fees by eliminating the current method of reimbursing doctors on the basis of "reasonable and customary charges" and setting prospective rates which are negotiated in advance for physician fees. Medicare cost containment cannot be confined to hospitals. It must include physicians, who play such a pivotal role in the medical care decision making process.
2. Another alternative would be freezing physician fees and mandating assignment. If physician fees were to be frozen without requiring physicians to accept assignment, charges that would normally have been reimbursed by Medicare would be passed on to patients.
3. Repealing immediately the return on equity allowance under current law for proprietary hospitals. Even though Congress has decided to phase out return on equity after fiscal year 1986, the need to reduce Medicare expenditures is so pressing, this decision bears reexamination.
4. Imposing a temporary freeze on new hospital construction. Until Congress determines how capital should be incorporated into hospital reimbursement rates a freeze would put the brakes on the dramatic rate of growth in uncontrolled capital expenses, which, inevitably result in higher operating expenses.
5. Repealing the excessive adjustment under the DRG system granted to teaching hospitals, based on the ratio of housestaff to the number of beds. Rather than simply doubling the current adjustment, Congress should develop a plan for supporting hospital-based teaching programs without burdening the Medicare program.

Taken together, the previous suggestions could save the Medicare program billions of dollars annually, far more than the $400 million spending reduction target for fiscal year 1984, and avoid any need to cut benefits or impose higher beneficiary cost sharing.

### MEDICAID

Since 1981 $4 billion has been cut from the Medicaid program. Federal matching rates have been reduced, and states were given more flexibility to cut elderly, disabled and poor families from their programs.

Since the Reagan Administration took office, one million AFDC mothers and their children have been terminated from the program. Twenty states have raised out of pocket payments for recipients; 30 states have cut back benefits and/or eliminated cost-effectaive benefits such as primary, preventive and ambulatory care.

Last March the Administration proposed to require states to impose copayments for services and reduce federal matching payments, which would result in states which have been unable to absorb past budget cuts, further reducing benefits and services.

We are pleased that the budget compromise did not call for any reductions in Medicaid for fiscal year 1984 and would allow funding in next year's budget for a child health assurance program which we have long supported.

The elderly and poor and single parents with children rely on Medicaid for hospital care, physician services and prescription drugs. Cutbacks in ambulatory care services have forced beneficiaries to go without essential physician services and X-ray and laboratory procedures and have led to greater acute expenditures and a greater need for long-term care for the elderly. For children, budget cuts have resulted in many areas in the first increase in infant mortality since World War II.

It is crucial that the Committee reject any proposals to reduce Medicaid expenditures. Further cutbacks in services could have a serious effect on the health of children, the elderly, the poor and the poorest jobless workers who depend on Medicaid program as their only access to treatment.

### AID TO FAMILIES WITH DEPENDENT CHILDREN

Since 1981 the Congress has enacted Administrative supported measures which have penalized the poor and rewarded the wealthy—making poverty a more severe and permanent condition for millions of low-income families. Workers and their families who have exhausted or were never covered by unemployment insurance are losing their homes, eating at soup kitchens, living in their cars, and wandering throughout the country desperately looking for work. Homeless and destitute people are being turned away at already overcrowded city shelters and churches. In some parts of the country "poor houses" have replaced the meager but more humane public assistance program.

Cuts of approximately $6.10 billion in fiscal years 1981 through 1985 have been made from the Aid to Families with Dependent Children program. Since the cuts enacted in 1981 and 1982, which total approximataely $1.5 billion each year, protection has been undermined for as many as 625,000 families of which 365,000 families were deprived of benefits altogether. A double blow was dealt to working poor families receiving AFDC benefits to supplement their low wages as their welfare supplements were eliminated and child care centers were closed to them. At the same time, states were encouraged to require the needy to work off their welfare payments in workfare programs. Families of strikers were deemed ineligible regardless of need—as were poor families of military personnel.

Already strict eligibility requirements have been made even more severe preventing jobless workers and their families from receiving any assistance now that they are in need. Families are barred from receiving AFDC if they have more than $1000 in assets, including the value of household items, and a car valued at more than $1,500. Few jobless workers can meet such low assets standards.

The budget policies of this Administration and the 97th Congress have had a devastating effect on the children in this country. Two and one-half million more children live in poverty today than two years ago. One and one-half million children have lost at least some of the critical support provided by AFDC. These children as well as others have lost food stamps, health care, school lunches and social services. Child abuse is on the rise and the infant mortality rate is on the increase. More children live in poverty than any other age group in the country and the poverty rate for children is climbing.

Although frequently obscured by the boasts of economic recovery, the evidence of continuing suffering is staggering. Despite the enormous pain inflicted on the nation's poor as a result of cuts already enacted, the Administration is seeking additional cuts in AFDC. We strongly urge this Committee to reject any further cuts.

We urge you instead to enact restorations which will begin to address the harm imposed by the previously enacted ill-conceived cuts:

1. Remove the unreasonable barriers which are preventing millions of jobless workers and their families from receiving assistance vital to meeting minimal family needs. Set aside the unrealistic asset and auto limitations and repeal the retrospective accounting provision requiring that eligibility for assistance be based on income no longer received.

2. Reject workfare mandate that requires all AFDC family heads—96 percent of whom are female single parents—one-third with children under 6 years of age—to work at jobs that pay no wages, provide no benefits and lead to no decent employment. Such programs neither relieve the American public from supporting these families nor increase the self-esteem or employability of the individuals forced into them. Being on a workfare assignment with no pay does not make someone a wage earner or get that person off welfare—participants have no more money, no better job prospects and no less welfare stigma.

3. Eliminate the cap on AFDC eligibility set at 150 percent of the state need standard which has eliminated any assistance for many working poor families. Every state's standard of need—and in 37 states even 150 percent of the standard of need—falls below federal poverty guidelines. In over 30 states, 150 percent of the standard of need is less than the monthly minimum wage for a 40 hour work week. These families should be helped to subsist until they are able to get higher paying jobs or increased wages on their existing low paying jobs.

4. Eliminate the four month limitation on the $30 and one-third allowable disregard which account for 26 percent of all case closures and 46 percent of all case reductions. This arbitrary limit bears no relationship to how long it may actually take a recipient to form an attachment to the labor force and move off the rolls without loss of income.

5. Raise the maximum amount of allowable work expense reductions from the current $75 a month to 20 percent of gross earnings. The arbitrary limit imposed in 1981 has in some areas been interpreted to include mandatory payroll deductions such as social security and federal taxes as well as transportation, uniforms and small tools. In some states minimum wage full time workers will have mandatory payroll deductions for federal, state and local taxes and FICA alone totalling $84 per month. Work expense allowed deductions must be changed to reflect the real cost of working.

The harm imposed by the ill-conceived budget cuts of the past two years must be addressed. Acceptance of these minimal restorations will begin to restore some measure of equity and fairness to the AFDC program and we urge their enactment.

### SOCIAL SERVICES—CHILD WELFARE—FOSTER CARE AND ADOPTION

For over a decade Title XX has funded supportive services which have provided individuals and families with community based services allowing them to avoid institutionalization; protected children in need of substitute care due to parental neglect or abuse; and enabled working poor parents to receive adequate care for their children during working hours. Although the need for more—not less—of these badly needed services is clearly indicated by the shocking frequency of reports of child abuse, family break-up and untreated mental and emotional illness, the Administration has successfully sought Congressional action which has seriously curtailed the program.

Services have been drastically reduced as a result of the 23 percent decrease in funding for Social Services and the reduction of the Child Welfare Service Program to less than its fiscal year 1981 funding level. At the same time funding reductions in the key income support programs—AFDC, Food Stamps and Medicaid—along with increased pressures on families caused by the general decline of our economy have significantly increased the demand for child welfare and other social services.

We urge this Committee to reject the Administration proposal to eliminate funding for the Work Incentive Program ($281 million), the Community Services Block Grant ($342 million) and a number of programs serving the elderly at ($56 million) while providing that they be continued as part of the Social Service Program. The cumulative funding total for these programs represents more than 25 percent of the current level of Title XX expenditures. We recommend that Title XX be maintained as a separate identifiable federal entitlement program with an increased authorized ceiling of $2.8 billion.

We urge you to reject the Administration proposal to cap Title IV-E of the Social Security Act which would eliminate the entitlement nature of the federal foster care program. As Congress recognized in enacting Public Law 96-272, an arbitrary cap on funding for out-of-home care will seriously jeopardize children in need of foster care or appropriate alternatives.

We also urge the Committee to reject the Administration proposal to maintain the Title IV-B Child Welfare Services Program at $156.3 million for the third year in a row. In order to continue the necessary reforms in the system and begin the preplacement preventive services, child welfare services should be fully funded at $266 million. Public Law 96-272 has never been fully implemented due to the lack of fiscal resources and the Administration's persistence in treating the law as though it is a block grant. Meeting the law's objectives requires funding the necessary amounts to implement the reforms necessary to assure children placement in permanent families whenever possible.

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AMERICAN PSYCHIATRIC ASSOCIATION,
*Washington, D.C., June 15, 1983.*

Hon. ROBERT DOLE,
*Chairman, Senate Finance Committee,*
*U.S. Senate, Washington, D.C.*

DEAR MR. CHAIRMAN: The American Psychiatric Association, a medical specialty society representing over 28,000 psychiatrists nationwide is pleased to provide our comments on the Administration's spending reduction proposals under the jurisdiction of the Senate Finance Committee and requests these comments be made part of the Committee's June 15-16, 1983 hearing record on this most important subject.

### MEDICARE

We recognize that the vast majority of savings to be achieved by your Committee have already been accomplished with the adoption of the Social Security Amendments of 1983 and the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 and that our testimony submitted previously to your Committee (on the subject of Medicare cost-sharing) raised serious concerns about the efficacy of increased copayments and deductibles under Medicare's Part A as well as increased premiums and a new indexing of deductibles under Part B to finance a "castastrophic" health proposal. Our testimony noted that while increased patient cost-sharing may achieve some cost savings through reduced utilization of physician and hospital services, the very same revisions on cost-sharing may have a perverse effect upon early intervention and prompt diagnosis of illness. If, as the Administration proposes, Part A copayments and deductibles are restructured we are concerned that patients would simply delay their physician encounter for entering the hospital and thus become more ill, and therefore in need of more intensive, longer-term care. Accordingly the proposal is a false economy.

We also noted that the increases in both the Part B outpatient premium and indexing the Part B deductible to the consumer price index would discourage both early interventive outpatient care as well as earlier entry into the hospital for necessary hospital-based treatment.

We urge rejection of these Medicare cost-sharing proposals. We also urge you to reject the Administration's catastrophic health insurance proposal, which it has tied to these increaed patient copayments and deductibles. That proposal would only benefit a small proportion of Medicare enrollees, and, unless amended, would provide no benefit to those receiving psychiatric care because of current Medicare limitations on the treatment of such disorders.

Moreover, the APA is concerned about the potential impact upon the retention and recruitment of medical school graduates into the field of psychiatry which would be engendered by a one-year freeze on physicians fees under Part B. As the Committee knows, psychiatrists are among the lowest-paid of all medical specialists, and the cost effective treatment they provide to the Medicare population is already hampered by the discriminatory ceiling placed on Medicare reimbursement for treatment of mental illness. We are concerned that this proposal would only serve to draw those entering the new field of geriatric psychiatry away from such practice. Congress has emphasized consistently the need for an adequate supply of psychiatrists to meet the needs of this nation's mentally ill elderly, notwithstanding other Administration fiscal proposals to vitiate clinical training expenditures.

### MEDICAID

The APA commends the Budget Committee for its explicit rejection of the Administration's plan to impose mandatory copayments on Medicaid patients—those least able to afford health care. We urge the Finance Committee to ratify that position.

We recognize the distinction between the House and Senate Budget Committees' funding to support a Child Health Assurance Program, and would hope the Committee would consider the more broad-based approach which better assures that both comprehensive mental and physical health care are provided to the low-income child population.

### HEALTH INSURANCE FOR THE UNEMPLOYED

The APA supports the establishment of a health insurance program for the unemployed and their dependents. We kow that non-discriminatory physical and mental illness health insurance coverage has already been developed by members of both the House and Senate, and hope to continue to work with the Committee, as well as other relevant House and Senate Committees to assure that the final program recognizes through appropriate coverage, the impact of one's loss of employment on both mental and physical health.

We urge, however, that revenue increases mandated under the budget reconciliation process—whether for this program or other heath care programs—does not include a ceiling on the amount of tax-free employer-paid health insurance premiums provided on behalf of private-sector employees. This proposal, if adopted, would have the effect of encouraging a shift to less expensive health insurance plans which traditionally severely limit or exclude coverage for mental and emotional disorders.

We look forward to working with the Committee to help assure that appropriate means of lowering health program costs can be found which will not act to the detriment of either the Medicare or Medicaid population, or irreparable damage existing already limited private sector insurance coverage of mental illness.

With best wishes,

Sincerely,

Melvin Sabshin,
*Medical Director.*

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Association of State and Territorial Health Officials,
*June 27, 1983.*

Senator Robert Dole,
*Chairman, Finance Committee,*
*U.S. Senate, Washington, D.C.*

Dear Senator Dole: The Association of State and Territorial Health Officials wishes to file with the hearing record on MCH Block Grants the attached statement adopted by the state health officials in annual session last month.

Your interest in the recommendation contained in this statement is appreciated; that: there should be no substantive changes in the MCH Block Grant: the authorization levels be increased; and the prohibition against transfer of MCH Block Grant funds be retained

It is our position that the health of mothers, infants and children can be best served at this time through continued public health efforts based upon these recommendations.

Sincerely yours,

Douglas S. Lloyd, M.D.,
*President, ASTHO,*
*Commissioner of Health, Connecticut.*

### Resolution No. 12—Maternal and Child Health Block Grant Legislation

Whereas, the enactment of the Maternal and Child Health Block Grant legislation (Title V of the Social Security Act) less than two years ago with the accompanying substantial reduction in federal funding for MCH Block Grant programs has, in many states, produced significant changes in these programs to which adjustments are still being made; and

Whereas, any further changes in these programs resulting from new amendments to the MCH Block Grant legislation may create significant dislocation from the administration and operation of the State Maternal and Child Health and Crippled Children's programs; and

Whereas, states have not, as yet, had sufficient experience with the MCH Block Grant legislation to allow a full and accurate assessment of its impact; and

Whereas, the most pressing problem currently facing the State Maternal and Child Health and Crippled Children's programs is inadequate funding; and

Whereas, it is necessary to ensure that these programs will have adequate resources to fulfull their mandate of providing needed services to mothers and children, including handicapped children: Now, therefore, be it

*Resolved*, That the Association of State and Territorial Health Officials support the position of the Association for Maternal and Child Health and Crippled Children's programs which is that there should not be any substantive amendments to the Maternal and Child Health Block Grant legislation, and further that the authorization levels of the Maternal and Child Health Block Grant should be raised, and both the maintenance of effort requirement in the Block Grant legislation, and the prohibition against transfer of MCH Block Grant formula funds to another Block Grant or grants at the state level, should be retained.

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## STATEMENT OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Blue Cross and Blue Shield Association is the national coordinating agency for 98 Blue Cross and Blue Shield Plans. We appreciate the opportunity to comment on the Administration's spending reduction proposals for programs within the jurisdiction of the Senate Finance Committee. Our comments are based on our experience both as Medicare intermediaries and carriers, and as a source of private supplementary coverage for 9½ million Medicare beneficiaries. Although the Administration's proposals address Medicaid and other programs, our comments will focus only on the Medicare program because of our extensive involvement with Medicare beneficiaries.

On May 16, 1983, the Association appeared before this Committee and commented on the Administration's proposals (in S. 642 and S. 643) for revising Medicare beneficiary cost-sharing requirements. In those comments, we emphasized that while restructuring Part A and revising the cost-sharing requirements for Part B would produce substantial reductions in Medicare expenditures, the burden would be passed on, either directly or indirectly, to the Medicare beneficiaries. That burden would be either in the form of increased out-of-pocket expenditures or in increased premimums for private supplementary health insurance.

In our testimony of May 16 we also commented briefly on the proposal to freeze physicians' reimbursement at the 1983 level for reasonable charge allowances. While such a proposal would undoubtedly save the program money, one of the undersirable effects would likely be a decision by some physicians to refuse to accept assignment. As a result, more beneficiaries would be required to pay the difference between the Medicare reimbursement and the physician's charge.

This statement will address several proposals contained in S. 641, Medicare Voucher Act of 1983, and S. 643, Health Care Financing Amendments of 1983.

### VOUCHERS

The voucher proposal would establish a voluntary, private coverage alternative for Medicare beneficiaries by expanding the authority established under TEFRA for payments on a risk basis to health maintenance organizations (HMOs) and other competitive medical plans. The proposal would require that such private alternatives offer a benefit package that covers at least those services provided under Medicare. Payments toward the cost of private coverage would equal 95 percent of the adjusted average er capita cost of providing Medicare services to beneficiaries who remain in the Medicare program. In addition, an annual open enrollment period would be required and private plans would be permitted to provide annual rebates of up to $500 to beneficiaries where the cost of coverage is lower than the Medicare payment amount.

The voluntary voucher proposal would not reduce Medicare spending in its initial years. The Administration has estimated no budget savings in fiscal year 1984 and a $50 million cost for fiscal year 1985 if its proposal were enacted. It should also be noted that the TEFRA authorities which the voucher proposal is designed to expand have not yet been implemented.

We believe there is a great deal of uncertainty about the implications of the voucher proposal on the Medicare program. We suggest that operating experience under the TEFRA HMO reimbursement provision is needed to assess whether the methodology for determining per capita payment rates assures actuarial equivalence as intended by the Congress, and whether additional safeguards are needed to protect beneficiaries where the financial viability of the private plan may be in jeopardy. We also are concerned that the rebate features of the proposal may further encourage the healthiest beneficiaries to select the lowest cost plans, whereas less healthy beneficiaries would choose the higher cost plans or remain in the traditional Medicare program. This "adverse selection" and the segmentation of the market that would result would encourage the "wrong kind" of competition among plans—based not on relative efficiency of operation, but on the characteristics of the people who select private coverage.

### CONTRACTS FOR MEDICARE ADMINISTRATION

The Association strongly opposes Section 121 of S. 643. That section would provide "increased Secretarial flexibility in entering into agreements for Medicare claims processing." We believe that the present system of negotiated budgets for contractors is serving the program well. Administrative costs per claims have shown a steady decrease over the years while the program savings achieved through audit and medical review activities have increased. We also believe that the primary focus of the Administration should be on assuring an orderly transition to the recently enacted prospective payment system for hospitals. This can only be achieved by utilizing an experienced contractor community.

Even in the absence of the current extraordinary need for administrative stability, we do not believe that the proposal will enhance the administration of the program. We know from experience that periodic rebidding carries with it a substantial risk of disruption in service to Medicare beneficiaries. This disruption cannot be measured in dollars and cents or unit cost. The GAO, on March 4, 1983, in its evaluation of the President's fiscal year 1984 budget proposals, reaffirmed its 1981 report that stated ". . . Medicare's experiments with competitive, fixed-price contracting have not demonstrated the success of this approach."

### UTILIZATION REVIEW

Section 125 of the bill would eliminate requirements that hospitals and skilled nursing facilities have a system in place to review the need for services furnished to Medicare beneficiaries. The Association suggests that utilization requirements for hospitals be kept intact until the new medical review requirements established by TEFRA and the Socical Security Amendments of 1983 are implemented. Also, since the new review functions will likely be initially focused on hospital inpatient care, and not for care rendered in a skilled nursing facility, we believe that utilization review requirements for skilled nursing facilities should be kept intact to ensure that only medically necessary care is provided.

### RAILROAD RETIREMENT BOARD CLAIMS

The Association supports Section 126 of S. 643 that calls for the elimination of the requirement for a Railroad Retirement Board contract. The General Accounting Office (GAO) has maintained that this particular contract is duplicative of other carriers' responsibilities within the same geographic area and is not cost-effective. The Association believes that eliminting this particular contract would result in increased claims volumes for the remaining carriers and thus help to lower overall unit costs. In addition, this provision entirely eliminates those costs associated with managing a carrier's operation for a specific type of Medicare beneficiary.

## Statement of the Consortium for Citizens with Developmental Disabilities Task Force on Medicare/Research: American Speech-Language-Hearing Association; Association for Retarded Citizens; Epilepsy Foundation of America; National Association of Rehabilitation Facilities; National Easter Seal Society; National Mental Health Association; and United Cerebral Palsy Association, Inc.

The Task Force on Medicare/Research of the Consortium for Citizens with Development Disabilities appreciates the opportunity to comment on the Administration's spending reduction proposals regarding Meicare. The Task Force is comprised of seven national organizations which represent individuals with disabilities. These organizations are very concerned about the potentially harmful effect of the Administration's Medicare proposals on beneficiaries who are disabled.

Under the Administration's 1984 budget plan, future outlays for Medicare would be significantly reduced. The bulk of the savings, approximately $710 million in fiscal year 1984, would be the result of increased cost to beneficiaries. The Task Force certainly recognizes the need to restrain Medicare spending. However, the cost-sharing and catastrophic coverage initiatives proposed in the Administration's plan would be devastating to most disabled Medicare recipients.

Currently, a Medicare beneficiary is required to pay an initial deductible on the first day of hospitalization. No further coinsurance payments are then required until the hospital stay exceeds 60 days. From day 61 onward, the beneficary bears an increasingly higher portion of the costs. Under present law, in 1984, a Medicare Part A beneficiary would be required to pay an initial, first day deductible of $350. For days 61 through 90, the benficiary would pay one-quarter of the deductible or $87.50. If the hospitalization continues, a beneficiary begins to draw on a non-renewable, lifetime reserve of 60 days coverage with a 50 percent copayment. Beyond this, the beneficiary is responsible for the full cost of hospitalization incurred for that particular spell of illness. In the case of individuals who are hospitalized in a psychiatric hospital, a further lifetime limit of 190 days of such care is imposed. After that limit is reached, the beneficiary is responsible for all costs associated with psychiatric hospital services.

The Administration proposes to restructure the copayment system so that costs would be shared during the first 60 days of hospitalization. Beyond 60 day, a "catastrophic coverage" plan would require no copayment from the beneficiary. Under the Administration's proposal, in 1984, a Medicare beneficiary would still pay the initial $350 deductible. On days 2 through 15 of the hospitalization, an 8 percent of deductible or $28 copayment would be required. From the 16th through the 60th day of hospitalization, the beneficiary would pay $17.50 or 5 percent of the deductible. After 60 days, all costs would be covered by Medicare. No upper limit would be imposed on the number of days covered for each spell of illness. In addition, the initial first day deductible would apply only to the first two spells of illness annually. However, once again, those admitted to a psychiatric hospital would still be subject to the limitation of 190 days of coverage in their lifetime.

The Administration points out that, under the proposed plan, a Medicare beneficiary spending 150 days in the hospital would have to pay $1,530. Under current policies, the same beneficiary would face out-of-pocket expenditures of $13,475. The difference between these two figures is indeed substantial. However, this particular illustration does not provide an accurate reflection of the overall effect of the Reagan plan. The number of Medicare beneficiaries who are hospitalized for 150 days or more represents only a very small proportion of total program enrollees. For the vast majority of Medicare beneficiaries, the Reagan initiatives represent an escalation in out-of-pocket expenses.

The average hospital stay under Medicare is 11 days. Under current law, an 11 day hospitalization would cost a Medicare beneficiary $350. The same stay under the revised copayment plan would result in a $630 out-of-pocket expense to the beneficiary.

A Medicare enrollee would need to be hospitalized for a period of at least 74 days before benefitting from the Administration's proposed "catastrophic coverage". The Administration estimates that 150,000 beneficiaries would exceed the 74 day length of stay in 1984. This number represents only 2 percent of the 7.5 million beneficiaries who are hospitalized annually. Furthermore, these 150,000 individuals account for only one-sixth of one percent of the total Medicare population.

The effects of these revisions would also fall unevenly on the Medicare population. For example, while the cost for Medicare beneficiaries with an average hospital length of stay would increase from $350 to $630, the cost for a Medicare patient rehabilitation services would increase almost threefold. Depending on the patient's condition, the length of stay for freestanding hospitals and units generally averages 25 days. The cost of an average stay for a Medicare beneficiary in a rehabilitation setting would, therefore, increase from $350 to $917 under the new cost-sharing plan.

It is clear that the Reagan cost-sharing and catastrophic coverage proposals are aimed at shifting a greater portion of Medicare expenditures on the beneficiaries. Despite Administration assurances that these measures are meant to encourage beneficiary cost consciousness and the efficient use of health resources, the bottom line seems more revenue-related than humanitarian. The net effect of these revisions is to place a large share of the medical cost burden on beneficiaries who are already struggling to survive in today's economy.

In 1984, Medicare will provide health insurance to about 2.9 million people with disabilities. On average, these individuals are higher users of Medicare-covered services than the elderly. As a result, the impact of the Administration's revised copayment plan would fall particularly hard on this group of beneficiaries. For the most part, Medicare beneficiaries who are disabled are not in a position to either absorb the higher rates or alter patterns of Medicare utilization.

Many Medicare beneficiaries who are disabled are in a tenuous financial position. Year-long costs associated with their disabilities are a constant drain on limited financial resources. Moreover, much of the health care required by these individuals is provided in nursing homes, on an outpatient basis or in the home. As a result, in addition to cost sharing under Medicare Part A, these beneficiaries face substantial out-of-pocket costs for other health care services. Under the Administration's proposals, the premiums and deductible for Medicare Part B coverage will be raised. The combined effect of these copayment hikes under Medicare Parts A and B will contribute further to the already staggering health-related expenses borne by these individuals.

Once again, the chronically mentally ill and others with mental or nervous diseases are particularly hard hit with copayment requirements. Medicare outpatient coverage is already limited to no more than $500 of service, for which Medicare will reimburse only $250 (instead of the 80 percent of customary fees, as is the case for other illnesses). Furthermore, psychiatric day treatment is excluded under Medicare, again requiring the mentally disabled to pay substantial out-of-pocket expenses for necessary care.

The Administration contends that one of the reasons for increasing the level of cost sharing under Medicare is to encourage more efficient use of health resources. This policy is intended to bring about a reduction in Medicare utilization through higher out-of-pocket expenses. It should be noted, however, that elderly and disabled individuals have less flexibility in altering their use of health care services. With respect to hospitalizations, the long term disabling conditions suffered by many of these people often necessitate treatment regardless of cost-sharing considerations. Rather than changing patterns of care, the proposed copayment plan would simply shift more of the cost of this care onto the beneficiary.

The likelihood remains, however, that some beneficiaries would resist or cut short hospitalization or other covered services if faced with the proposed copayment plan. In order to avoid cost sharing requirements, these beneficiaries might postpone needed care until a deteriorated medical status compels them to seek treatment. The Task Force does not believe that these individuals should be forced to make such choices. Furthermore, from a cost-benefit standpoint, delayed care often results in more extensive and, thereby, more expensive treatment.

In view of the potentially harmful effects of the cost sharing proposals on Medicare beneficiaries, particularly those beneficiaries who are disabled, the Task Force urges the Committee to reject the Administration's Medicare spending reduction proposals. The Task Force firmly believes that implementation of the cost sharing and catastrophic coverage plan, coupled with increases under Medicare Part B, would prove a tremendous burden for beneficiaries. The substantially higher cost associated with these proposals would adversely affect both the health status and financial stability of the individuals.

Lastly, the Task Force strongly endorses the reconciliation instructions issued by the House and Senate conferees on the First Budget Resolution, which directed that "none of the savings to be achieved for the Medicare program shall come from provisions to increase costs to beneficiaries or from reductions in services to beneficiaries." We recommend that the Committee continue to examine methods by which Medicare spending can be controlled. However, we believe that such savings should not be derived by shifting the burden of cost onto the Medicare beneficiaries or by reducing inpatient and outpatient services and benefits.

We hope that these comments will be useful to the Committee.

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College of American Pathologists,
*Skokie, Ill.*

Hon. Robert Dole,
*Chairman, Senate Finance Committee, U.S. Senate, Washington, D.C.*

Dear Mr. Chairman: On behalf of the members of the College of American Pathologists, we would like to take this opportunity to express our strong reservations about two spending reduction proposals which may be considered by the Senate Finance Committee this week.

The first proposal, addressing competitive bidding for laboratory services (Blue Book, June 1983, item 10, page 13) under the Medicare Program, will create adminstrative problems and place new restrictions on Medicare beneficiaries entitled to prompt, efficient, and high quality laboratory services.

The College's opposition to the use of competitive bidding stems from concern that such a proposal will lend itself to the delivery of poor quality laboratory services and place artificial barriers for Medicare beneficiaries in obtaining high quality health care. The delivery of high quality health care would become secondary to the Government's effort to achieve a reduction in program costs.

This proposal is similar to one authorized by the Omnibus Budget Reconciliation Act of 1981 which provided for competitive bidding for clinical laboratory services under the Medicaid Program. Thus far, this proposal has not been implemented on a wide scale. Little or no savings have been achieved under this authority since 1981.

Under the 1981 Act, the Secretary of the Department of Health and Human Services is directed to monitor the program and to report to the Congress in 1984 on the operation of the program. Since there is little practical experience with such a proposal up to this point as it has not been utilized under the Medicaid Program, it would seem premature to authorize the use of competitive bidding for the Medicare Program. We would recommend that the extension of any new authority for competitive bidding under Medicare be delayed until the 1984 report on the Medicaid experience is issued to better judge whether such a proposal is practical. It is our further understanding that a Department Task Force on laboratory services is also studying this issue, but has reached no conclusions on the matter.

We would urge your subcommittee to reject this proposal on the basis that it would limit access to high quality health services and would not contribute in any significant manner to achieve cost-effectiveness in the Medicare Program.

The second proposal about which the College has strong reservations concerns an amendment we understand Senator Heinz may introduce that would require that laboratories be paid for low cost tests for Medicare beneficiaries at the same charge levels as for physicians. Laboratories would be required to accept this amount as payment in full and waive Part B deductible and coinsurance requirements.

While on the surface there appears to be a discriminatory treatment in the way certain independent laboratories bill for their services, there is a legitimate reason for such differences which are based on the cost of doing business with various purchasers of clinical laboratory services. One of the stated purposes of the pending proposal would be to eliminate the differing fee schedules and establish one comparable to the alleged lower schedule used in billing physicians' offices. The pending proposal, if adopted, could bring about just the reverse whereby independent laboratories would maintain one high fee schedule for all purchasers of services.

In view of the existing controls of Medicare and Medicaid over clinical laboratory services and fees for such services—including the prudent buyer principle and the current fraud and abuse rules—the College would recommend that this amendment not be adopted.

In summary, the College urges your committee not to adopt the proposal to authorize competitive bidding for laboratory services under Medicare and the lab payment amendment not be adopted on the basis that neither one will achieve their stated aim.

Sincerely,

JAMES D. BARGER, M.D.,
*President, College of American Pathologists.*

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